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ABSTRACT

The National Institute of Child Health and Human Development (NICHD) Study of Early Child Care is an ongoing, prospective, 3-year longitudinal study of over 1,300 full-term healthy infants and families from 10 sites across the United States. While the sample is not nationally representative, the subjects come from major regions of the country: the East Coast, the West Coast, the Mid-West, the North, and the South. They come from urban and from rural settings, and include minorities as well as single-parent and two-parent families. The study examines the concurrent, long-term, and cumulative influences of variations in early child care experiences on the cognitive, linguistic, social, emotional, and physical development of infants and toddlers. The study design takes into account the complex interactions among characteristics of the family and home, of the child care environments, and of the child. Subject recruitment started in January 1991, and data collection was scheduled to end at the beginning of 1995. Data collection involved periodic telephone calls to families beginning at 3 months and home visits, child care center visits, or laboratory assessments at 1, 6, 15, 24, and 36 months. This document is volume 4 of a 5-volume operations manual that explains, in 29 chapters, the procedures used in conducting the NICHD study. Volume 4 consists of chapters 20 through 24, which describe the 24-month visits and assessments, except that the volume begins with chapter 13 reproduced from volume 3. This chapter provides instructions for conducting follow-up telephone interviews at 13 and 23 months. Chapter 20 presents an overview of the visits to the child's home and child care center, and laboratory assessments at 24 months. Chapters 21 and 22 outline the procedures to follow in the visits to the child's home and child care center at 24 months. Chapter 23 provides instructions for: (1) conducting the 24-month laboratory visit; (2) observing and coding children's solitary play, and assessing children's compliance during a clean-up activity; (3) administering the Bayley Scales of Infant Development; (4) videotaping mother-child interactions; (5) conducting standardized interviews and questionnaires; and (6) measuring children's physical growth. Chapter 24 presents instructions on making follow-up telephone calls at 27, 30, and 33 months. (BC)

ED 403 986

NICHD Study of Early Child Care

VOLUME IV

23 Month Manual
24 Month Manuals

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Chapter 13

ADMINISTRATION MANUAL FOR THE 13 AND 23-MONTH PHONE INTERVIEW

I. PURPOSE OF THE MANUAL

This manual provides specific information about the questions included in the 13 and 23-month phone interview. In addition, this manual serves as the archival description of the way in which these phone interview data were collected. Many of these procedures are identical to those implemented for the follow-up phone contacts (the 3-, 9-, 12-, etc. month calls). It is modelled on the 5-month call developed by Deborah Phillips.

This manual will be modified if necessary during training and data collection. Any suggestions for additions or amendments should be addressed to Deborah Vandell at the Wisconsin site, Deborah Phillips at the Virginia Site and Bonnie Knoke at the Data Coordinating Unit.

If you have a question about any aspect of these calls, send a computerized mail message to Deborah Phillips and the Data Center. The questions and their responses will be sent to ALL sites.

As a prelude to studying this manual, we recommend that each caller review the information about standardized interviewing techniques contained in the home visit manuals.

II. OVERVIEW OF THE INTERVIEW

The 13 and 23-month telephone contact serves several purposes. First, it is used to obtain current child care information. In these cases, "current" means that the data for these calls need to reflect the target child's child care arrangements (or lack thereof) at 14 months and 24 months. THESE CALLS ARE INTENDED TO REFLECT THE CHILD CARE ARRANGEMENT THAT IS OBSERVED, IN CASES WHERE THERE IS OBSERVABLE CARE. IF YOU HAVE MADE A PRIOR CALL THAT DOES NOT CAPTURE THE OBSERVABLE ARRANGEMENT (I.E. AT THE HOME VISIT YOU LEARN THAT THE FAMILY HAS SWITCHED FROM THE GRANDMOTHER TO A FAMILY CARE DAY CARE HOME), THEN YOU MUST REPEAT THIS CALL, FROM START TO FINISH.

Second, it is used to determine whether, for children in child care, any of their current arrangements fit the criteria for "primary child care arrangements" that we will observe at 15 and 24-months.

Third, it is used to obtain information on changes in child care arrangements since the 12 or 21-month follow-up phone call.

Fourth, it may be used to schedule the 15 and 24-month home and lab visits. Although the manual makes the assumption that the 13 and 23 month caller will schedule the home, lab, and child care visits, sites are permitted to adjust this procedure to meet their needs. For example, sites may choose to let their home visitors (RAs) schedule these visits in a separate call.

Just be sure not to overburden the families with too many extra phone calls and keep the data collection within the windows. It is important, however, that these schedulers use the language from the scripts in the 13/23-month (see pgs 68 - 69 in this manual) calls when describing the relevant assessments.

Fifth, at 23 months it is used to obtain information about the number of hours mothers are working. This information is used to determine if the Job Experience questionnaire is placed in the questionnaire packet left with the mother at the 24-month home visit. The 23 month phone caller prepares the questionnaire packet for the 24 month home visit.

There are several possible outcomes of this interview:

1. CHILD is not currently in any form of child care ("no" to Question 14); the mother is currently not working or going to school ("no" to Question 16); and she does not expect to be using regular care, working, or going to school at the time of the child care assessment ("no" to Questions 15 and 17), or to change arrangements before the next child care assessment ("no" to Question 45).

In this case, you will schedule the 15 and 24-month home and lab visits and there will be no child care visit at 15 or 24-months (whichever applies).

2. CHILD is in some regular child care ("yes" to Question 14, or "yes" to Question 16 and you learn that mother takes care of CHILD at home, or takes the child to work, or does actually

have some other form of regular care), but it does not fit our criteria as a Primary Child Care Arrangement for a 15 or 24-month child care visit. If the mother does not expect to change child care by the time of the next child care assessment ("no" to Question 45), you will schedule the 15 or 24-month home and lab visits and there will be no child care visit at 15 or 24-months (whichever applies).

If the mother does expect to change child care within the next two months (by the time the child is 15 or 24-months old, see 4, below.

3. CHILD is in some regular child care ("yes" to Question 14, or "yes" to Question 16 and you learn that mother takes care of CHILD at home, or takes the child to work, or does actually have some other form of regular care), and it does fit our criteria as a Primary Child Care Arrangement for a 15 or 24-month child care visit.

In this case, you will need to follow the script in Part 5 to determine the primary child care arrangement and set in motion the process of contacting the caregiver about the visit. This can go one of two ways:

(a) Either the mother gives you permission to contact the provider directly, or

(b) She wants to contact the provider first, in which case you will need to re-contact the mother to find out about the outcome of her contact prior to making a direct caregiver contact.

You will also schedule the 15 or 24-month home and lab visits.

4. CHILD is not currently in any form of child care ("no" to Question 14); the mother is currently not working or going to school ("no" to Question 16); BUT the mother does expect to be using regular care, working, or going to school by the time of the next child care assessment ("yes" to Questions 15 and 17), OR she expects to change her child care arrangements by the next child care assessment ("yes" to Question 45).

In these cases, you will obtain the information about what the mother plans to be using for child care (see Question 46) and should have this information handy when you make the call-back. You then need to schedule a call-back to the mother at the time that her new arrangement is in place (but no later than 15 mo, 0 days or 24 mo, 0 days), approximately 3 weeks after this call, and redo the entire interview. This repeat interview will then serve as the data from which to determine whether to conduct a 15 or 24-month child care visit. DO NOT SEND THE MARK-SENSE FORMS FROM THE FIRST 13 or 23-MONTH CALL TO THE DATA CENTER. Send ONLY the second interview to the Data Center. However, we recommend that you schedule the 15 or 24-month home and lab visits after the first interview.

PLEASE NOTE: Your ultimate goal is to assure that observable child-care arrangements are assessed prior to the end of the allowable windows (16 mo or 25 mo 0 days with exception periods extending to 19 mo or 29 mo 0 days). Section III.A. describes the minimum number of required calls, and procedures for repeat attempts to reach the families. You will need to adapt these procedures for individual families. For example, some families may tell you that they are starting a new arrangement at 14 months, 2 weeks, but you learn that the switch has been delayed another week. In this case, you will need to make a second, call-back appointment.

Sometimes a family will start to change child care WITHIN the windows for data collection. If you are aware of this change/start-up in advance you may have a choice about which child care to observe. Please use the following guidelines in this situation.

(a) Observe the "old" arrangement if observing the new arrangement pushes you close to the end of the window. This will often be the case given the two week waiting period before an observation can be made.

(b) Observe the "old" arrangement if it lasted for three or more months.

(c) Observe the "new" arrangement if the "old" arrangement consists of father care, but ONLY if you are confident that you can schedule the child care visits within the window.

For example, if you know that a family is switching child care at 15 mo, 1 week, you will need to decide whether to observe the old arrangement at 15 months (highly preferable: first visit at 14 mo, 3 weeks and second visit at 15 mo, 0 weeks) or whether to see the child in his/her new arrangement after the required two weeks of adaptation (first visit at 15 mo, 3 weeks, second visit prior to 16 mo, 0 weeks).

Sometimes you will make the call-back and discover that the family has NOT changed child care. In this case (assuming that the "old" arrangement is not going to change in the next couple of weeks), check with the mother to see if the information from the original call is still accurate (e.g., hours of care each day, address of arrangement) and schedule the child-care visit. Send the original call to the data center if nothing has changed.

We suggest that you retain the 13 and 23 month call forms until the child care visit is completed for any given target child. This will avoid situations in which initial call data are sent, and then you discover a subsequent change in arrangements that necessitates a call back, and a second set of data being sent to the Data Center.

If you want consultation on these "in-between" and unusual cases, call Deborah Phillips at the Virginia site.

III. INSTRUCTIONS FOR CALLING

The 13 month call may be started at 12 months 14 days (2 weeks prior to the child's 13 month birthday). The 23 month call may be started at 22 months 14 days. There are no close dates for these windows and there are no exception periods for these calls. Again, use these calls to schedule the 15 month and 24 month lab, home, and child care visits within their windows.

It is important for sites to make conscientious attempts to reach the mothers. By this visit, we have significant resources invested in these families; failure to contact the families results in a smaller sample. If the family has a phone but the mother has not been contacted in the first 3 days of regular attempts, efforts should be increased to include evening and weekend calls. A minimum of seven calls should be placed during the first week's attempts - three evening, two morning and two afternoon calls. If the mother is not contacted by the end of the first week of attempts, initiate the procedures outlined under What to do if you cannot reach the family by phone. If the mother is not reached by any of these means at 13 or 23 months, the same set of seven calls for contacting the mother should be repeated at 15 or 24- and then again at 16 or 25-months, if needed. Again, these particular dates are not etched in stone. Your goal is to assure that we obtain the necessary information for the childcare, home, and lab visits at 15 and 24 months, within the allowable windows.

The child's mother must be contacted and interviewed in all cases. The only exception to this rule are situations where the mother is out of phone range for some unusual reason (serving in the military, for example) and will not return until after the data collection window is closed. In this case, conduct the interview with the child's father if possible, or, if there is no father involved, with the child's primary caregiver. Indicate on the interview face sheet the relationship of the person who has been interviewed (0 = mother, 1 = father, 3 = grandmother, 4 = other adult relative, 5 = unrelated adult, 6 = sibling, 7 = other). If the mother is out of town but able to be called, she should be contacted wherever she is. Similarly, if the mother is out of contact for a short period of time (as in the hospital), arrange to call her back when she has returned home if this will be within the window for data collection.

If the mother is no longer living in the same household with the child, determine who the child's primary caregiver is. This caregiver of the child should then be contacted and informed about the study. If he or she is interested in participating, a home visit will need to be made to obtain informed consent. At this time, the information for the update can also be obtained using the appropriate alternate caregiver forms (See chapter 15.5).

With respect to the 15 month lab visit, if you find during this call that the primary caregiver has changed, you must determine who is the current caregiver and what their past relationship has been with the child. If the current caregiver is someone who has:

(a) lived with the child more than 2 months

OR

(b) has had frequent interaction with the child in the past (at least weekly),

...then we will do the entire protocol with that caregiver, including the Strange Situation. If they have not had weekly contact in the past and/or have not had primary care of the child for the last 2 months, then everything in the protocol will be conducted with this caregiver except the Strange Situation. You can get this information by asking questions like the following:

When did you assume primary/major care of the child?

What was your relationship to the child before this time?

Did you live with the child?

Did you see the child on a regular basis, at least once a week?

Did you take care of the child at least once a week?

Please make a special note of any cases where the primary caregiver is no longer the mother, and indicate whether the lab should or should not include the Strange Situation for this child/caregiver dyad. COMMUNICATE THIS INFORMATION TO THE 15-MONTH LAB TEAM AND SCHEDULER. If you have any questions about this procedure for non-maternal caregivers, please contact Sue Spieker at (206) 543-8453 or Martha Cox at (704) 438-6532.

A. When to make the calls

The window for making the 13 or 23-month calls to the family begins when the child is 12.5 or 22.5 months. You do not need to start making the calls at 12.5 or 22.5 months. Again, use your best judgment about what is going to enable you to schedule all of the visits for each age group. If the mother is not reached, a minimum of seven calls should be attempted (consisting of at least three calls during the evening, two calls during the morning, and two calls during the evening). If the phone has been disconnected, the number is changed to an unlisted one, the family does not have a phone, or if there is no answer, follow the procedures outlined in Subsection E, "What to do if you cannot reach the family by phone."

If all of the procedures fail, wait until the child's 15 or 24- month birthday and repeat the call sequence of a minimum of seven calls. Repeat at the 16 or 25-month birthday if necessary.

B. What to do if you cannot complete the interview in a single call

Families with young children have to cope with a lot of interruptions. If the interview cannot be completed at one time, arrange a specific time to call back before the end of the following day. Thus, the second call should be within 36 hours of the first call. If this is possible, the second interview can proceed from the point where the first interview left off. If more than 36 hours elapse between calls, start the interview over at the beginning. Say something like, *"I'm going to start at the beginning to be sure we haven't forgotten anything,"* and use confirmatory language (e.g., *"You are using regular child care?"*) for the repeat questions.

C. How to leave a message

If you reach the family's home but are unable to talk with the mother, leave a specific message, including a time when you will call back. A suggested message to leave with another person follows.

> *"This is YOUR NAME from the NICHD Study of Early Child Care at the University of _________. We visited with MOTHER'S NAME about ___ months ago, and I am calling to see how she and CHILD are doing. She can reach me at PHONE NUMBER and DAYS/TIMES. I know she's very busy so*

I'll try to reach her again. Do you know of a good time for me to call? Thank you." (Record date and time.)

D. An alternative message for an answering machine

"This is YOUR NAME from the NICHD Study of Early Child Care at the University of ___________ calling for MOTHER'S NAME. We visited with you in MONTH, and I am calling to see how you and CHILD are doing. You can reach me at PHONE NUMBER and DAYS/TIMES, and I'll call back DAY/TIME. Thanks."

E. What to do if you cannot reach the family by phone

If the family does not have a phone, their phone is disconnected, their number has been changed to an unlisted one, or after a week of trying at all times of day and evening you have not contacted the family, special efforts must be made to reach the mother. The following steps are recommended:

1. Call work numbers if available. Unless parents have explicitly asked you not to call them at work, call the work numbers for either or both parents to arrange a convenient time to conduct the interview.
2. Make a home visit. When possible, the most effective approach to contacting a hard-to-reach family is for a project staff member who is acquainted with the mother to stop by the family's home. Often, people will not

have moved if their phones are disconnected or changed to an unlisted number. The home visit should always be carried out by someone who has met the family, and preferably someone who has been to the home before (the 6-month home visitor, for example). If the family has no phone, the interview can be carried out in person, or an alternate arrangement can be made for the interviewer to collect the information from the mother. If no one is at home but it looks as though the mother still lives there, leave a letter or card asking her to contact the project office. Be sure to let her know she can call collect.

3. Call the family's alternate contacts. Alternative phone numbers which are obtained in the hospital and/or at 1 month, and which are updated at each contact point, are useful primarily for obtaining new addresses and phone numbers for study families. Leaving messages at the homes of alternative contacts is generally not productive, although it can be tried. Asking alternative contacts to go and get the mother while you wait on the telephone is an imposition, and is not recommended. If the alternative contact can provide a new phone number or address, follow up on that by calling or making a home visit.

4. Send a letter with the project phone number and a return postcard to the family's last known address. (Use sample letter included the 15- or 24-month Appendix.) This prompt is often enough to encourage mothers to call you, or to send you their new address or phone number. Then you can follow up with a phone call or home visit. Be sure to let the mother know she can call you collect. Mark the envelope Address Correction Requested in order to receive a new address.

5. Call directory information in surrounding areas. The family may have moved nearby and still have a published phone number.

6. Check with the post office. Provide the family's last known address to the post office and ask for the newest address for the family. The post office will charge $1.00 per name to give the most recent forwarding address.

F. What to do if the mother says she no longer wishes to participate in the study

When a mother tells you she wishes to withdraw from participation, ask *"If you don't mind, can you tell me why you* *don't want to continue?"* Very politely, and without being insistent or coercive, try to reassure the mother.

> If she says she's too busy, having another baby, going back to work, or just feeling overwhelmed, say
> *"Yes, you must be really busy, especially with all these new demands on your time and energy. We do our best to make things as easy as possible for you. There are no more than two visits per year, and we like to schedule them at your convenience. We can work around the other demands on your time."*
> If she still feels this is not a good time to be in the study, say
> "Would you prefer for us to wait and call you again in a few months?"
> The regular phone calls will then continue to be made. Possibly the family could then be observed at 24, 36 months.
>
> If she says her husband/partner doesn't want her to continue, say
> *"What does he seem to be concerned about?"*
> Then listen. Acknowledge the mother's concerns. When she is done and leaves time for you, provide supportive information, and ask

"Would you like me or SITE P.I. to call him and talk with him about our study? We would be more than happy to speak with him."

Arrange a time to call if this would be helpful.

If mother continues to say she wants to withdraw, say, *"I'm sorry you feel you cannot continue. We would very much like BABY to have the opportunity to participate in what we think is a very important study. But I certainly understand your feelings. If you change your mind, please call us. Again, our phone number is ____________."*

Fill out the form for recording dropouts and send it to the Data Center.

G. What to do if the mother refuses to schedule one of the three visits: child care, home, lab

When a mother tells you she cannot participate in one of the visits, ask *"If you don't min, can you tell me why you don't want to participate in the home/playroom/child-care visit?"* Very politely, and without being insistent or coercive, try to reassure the mother.

See specific instructions for F above.

It is possible, for example, that the mother is uncomfortable with being video-taped at home or in the lab.

Reassure her that the data will be completely confidential and that no names are included on the tapes, etc. If she remains uncomfortable, you may eliminate this portion of the visit and retain the rest. Some data is always better than no data. Also, it is crucial that we keep these families involved and invested in the study. If we are quick to eliminate an entire visit, then we send a signal that partial participation is okay.

Be sure to inquire about helping out with transportation and babysitting.

Some sites may also have a set of mothers who have participated in each assessment who are willing to talk with other mothers; sometimes the reassuring voice of a participant is exactly what is needed. Of course, you would FIRST need to ask the reluctant mother if she would like to talk to another participating mother and, if yes, does she mind if you give out her phone number. THESE COMMUNICATIONS MUST BE KEPT CONFIDENTIAL. One mother is calling another mother -- no names involved.

However, if the mother insists that she cannot participate in one of the visits (see H below concerning the child care visit), then say *"I'm sorry you feel you cannot be part of the home/playroom/child-care visit. We would very much like CHILD to have the opportunity to participate in what we think is a very important study. But I certainly understand your feelings. If* *you change your mind, please call us. Again, our phone number is*

________________.*"*

H. What to do if the mother says the child care provider will not participate in the study

"What does she/he seem to be concerned about?"

Then listen. Acknowledge the provider's concerns. When she is done and leaves time for you, provide supportive information, and say:

"Sometimes it helps a lot for us to talk to the provider and to answer (his/her) questions. Do you mind if we do this?"

IF NO, follow procedures for contacting the provider directly.

IF YES, ask *"Can you tell us a little about why you don't want us to call your provider?"*

Try to address the mother's concerns, but don't be so persistent as to jeopardize the mother's continuing participation in the study.

IV. RECORDING CALLS

The form labeled RECORD OF CALLS (Form 10C, Page 3) is for use at sites to keep track of all attempts to reach a mother. Every time the caller attempts to contact the mother, the date and time should be recorded and the result coded according to the codes listed at the bottom of the sheet. The interviewer's code or initials should also be marked on this sheet so that if more than one caller is trying to reach the mother, each one will know who has already left messages with the family. Any special situations should also be recorded on the reverse of this form. The Record of Calls is retained at the site in the family's confidential folder.

V. FORMAT OF THE PHONE UPDATE INTERVIEW

Every interviewer should become thoroughly familiar with the format, layout, and questions of the interview. Because of the many different situations we expect to encounter during this study, the questions have been written to try to cover a great variety of responses.

The interview consists of two sets of forms: (1) forms for recording information - the FACE SHEET, RECORD OF CALLS, CURRENT CHILD CARE GRID, INFORMATION SHEET FOR 15 and 24-MONTH CHILD CARE OBSERVER, INFORMATION FOR 15 and 24-MONTH LAB VISIT, AND INFORMATION FOR 15 and 24-MONTH HOME VISIT, and (2) the actual 13 and 23-month interview and script.

Within each section of the interview, there are a number of choice points when the interviewer must skip over particular questions or sets of questions because they are not relevant to a particular situation. It is important that each caller be completely at ease with these choice points so that the interview can proceed smoothly and keep the mother unaware of the many coding decisions and question selection decisions the interviewer is making.

The conventions followed in this interview protocol are:

1. The directions to the interviewer that are not intended to be read to the mother are printed in ALL CAPITAL LETTERS. The questions and comments to be read to mothers are printed in upper and lower case type.
2. The interviewer is expected to continue to the next question unless instructed otherwise by a GO TO or choice point instruction.
3. Questions that must fit more than one situation are worded so that the choices between two wordings are in parentheses. Example: Last time we talked you (were/were not) going to school. The interviewer is expected to choose the correct wording for the particular situation, not read both options. This requires that the interviewer have the questions clearly in mind, understand the different possible situations to which they refer, and have information about the family available.
4. Questions in which a person's name (or other specific information) is to be used indicate the missing information in capital letters, as, for example: Has CHILD had any ear infections? The question should be read as, Has Samuel had any ear infections?

VI. MARKING THE FORMS

The mark-sense forms used for the interview must be filled in carefully. Use a #2 pencil and be sure to blacken the entire space to indicate the mother's response. Whenever there are two columns of numbers, as for month and day, for example, mark both columns. If your response requires only one digit, mark 0 in the first column.

For example, to record a date of March, 1992:

MONTH	YEAR
0 3	19 9 2
▬ 0	0 0
1 1	1 1
2 ▬	2 ▬
3 3	3 3
4 4	4 4
5 5	5 5
6 6	6 6
7 7	7 7
8 8	8 8
9 9	▬ 9

Write the date in numerals on the top line, then mark the corresponding digits in the mark-sense columns below.

VII. INTERVIEW SCRIPT

The 13 and 23-MONTH TELEPHONE INTERVIEW will be used at 2 timepoints. It is essential that the boxes indicating the correct time point be marked at the beginning of the phone call. This script contains all of the introductory information you need to explain to the mother what is going to happen next. At the beginning of the interview, you may also find it helpful to add some informal conversation with the mother to make her feel comfortable, but do not spend too much time chatting before getting down to work. The mother appreciates your friendliness but will also appreciate not being kept on the phone too long.

Once you begin the questions, they must be read exactly as they are written, with two exceptions: (1) You will have the occasional situation where the information requested is obvious or already known to the interviewer. In these cases, the interviewer may reword the question as a statement, confirming with the mother that the information obtained previously is accurate. (2) The use of the term "arrangement" seems too formal for the type of care being discussed. This is likely to happen with father care or when mothers are child care providers. In these situations feel free to substitute language such as, "How many hours a week does your husband take care of Sam?" For a few questions (e.g., Q39), alternative wordings have been provided.

Mothers have different ways of responding to interview questions. Some are very precise and specific, but others tend to give vague responses or answer in general ways that are not codable. You can encourage mothers to be more specific by enlisting them as partners in the process of data collection. For example, if a mother responds to the question,

"*How many hours a week do you work?*"

by saying

"15 or 20 hours."

you can say,

"I need to record a specific number of hours. Please give me your best estimate of the number of hours you work in a typical week."

The next time the mother responds with a range of numbers instead of a single answer, follow the same procedure. Usually after two reminders, mothers will understand the requirements of the interview and begin to give you codable responses without prompting.

Finally, this interview requires some flexibility in wording, especially when obtaining the information about current care arrangements and completing the grid (questions 26-37), given the wide range of possible responses. The important thing to keep in mind is that you need to get all of the information requested to complete the grid. You will not always need to ask each question. For example, if you know that the mother is the child care provider, you do not need to ask about the sex of the provider. Use common sense!

VIII. INTERVIEWING TECHNIQUES

Be sure to read all questions exactly as they are worded. If the wording seems awkward to you, practice saying the questions aloud until you feel comfortable with them.

On some occasions, mothers may volunteer information during one part of the interview that you will ask them for later. Remember what they have said, but do not flip through the interview pages to record that information. Instead, when you come to the relevant section, confirm the information you have received and ask, *"Is there anything else?"* For example, after asking the mother the first question about use of regular child care, she may volunteer that she takes CHILD to a day care center. Then, when you get to Question 26 you can say, *"You mentioned that you take CHILD to a day care center. Who takes care of CHILD there?"* But don't forget to probe for additional arrangements. Whenever you are confirming information with the mother, use the wording of the question as written to the greatest extent possible. It is essential that you cover the content of every question. Do not assume information without confirming it, even if it seems self-evident.

Because the interview cannot exactly fit every possible situation for all the mothers in the study, there will at times be questions that seem to you inappropriate. In these unusual cases, you can say something like, *"The next question asks..."* Done politely and without belittling the question, this approach lets the mother know you are attuned to her individual situation, but also that you have a job to do and you take it seriously.

Do not interpret or reword questions. If a mother asks for clarification of a question or word, try repeating the question, perhaps with a slight change in intonation. Sometimes mothers may ask the meaning of a question that has a set of multiple choice answers. In this case, you can read her the options so she can select one of the choices.

IX. PREPARING THE MOTHER FOR INITIAL CONTACT WITH PROVIDER

During the phone call with the mother, tell the mother that you wish to visit and observe the child in his/her child care arrangement; tell her in general the purpose of the observation, what you hope to find out, and how you will do it. Usually, you will then ask the mother's permission to contact the care provider (the program director or the direct child care provider) directly about the visit. In some cases, though, it may be the better part of valor for the mother to approach the care provider first. Use your judgment; the important thing is to obtain the consent for the visit -- whatever it takes. If she wants to, the mother can mention to the caregiver that we will be calling him/her, but not seek his/her permission to visit. Alternatively, the mother may want to handle setting up and scheduling the visit herself. Or, finally, what may work best is for the mother just to give you the provider's name and for you to take it from there.

If the mother opts to be the person to contact the caregiver, you will schedule a call-back (as soon as possible, but no more than 10 days after the initial call) and inquire about her contact with the provider.

Successful contact: Thank the mother for her assistance and proceed to provider contact.

Unsuccessful contact: In some cases, the provider will tell the mother that he/she does not want to be contacted by the research team. Try to find out why this has occurred. In some instances (e.g., the mother thinks the provider is wavering), you may deem it appropriate to contact the provider anyway, but be sure to ask the mother's permission to do this. In other instances, both mother and provider will be adamant about refusing the child care visit. If the child does not have a secondary arrangement in which he/she is enrolled for at least 10 hours a week, we have a missing child care observation. If there is an appropriate secondary arrangement, ask the mother if we can repeat the recruitment process for this provider.

TROUBLE SHOOTING: If the mother seems reluctant to talk to the provider about the visit (or to have you contact the provider) or to have the child observed in child care, ask her why. If possible, use one of the following suggestions to address specific concerns:

A. The mother feels the child has not been in the arrangement long enough. Explain we do not observe a child unless he/she has been in the new arrangement for at least 2 weeks. Our experience has shown us that for our purposes, this seems to be enough time for both the child and caregivers to adjust to a new situation.

B. The mother feels the observations would be asking too much of the provider. If the mother is concerned because the observer could be intrusive or disruptive, explain that we will describe the study in detail to the provider, and arrange times for the visits that are convenient to the provider. Mention that we tell the provider not to make any special arrangements, and that we will respect the routines and responsibilities of the caregivers during the visits. Emphasize that after we explain the study to the provider, we ask for the provider's separate consent to participate in the study.

C. The mother feels the study would not be of enough interest to the provider. Explain that we will send the provider information about the study before calling, and emphasize that observing the child when he/she is away from the mother is important to our understanding of how a child develops. We will explain to the provider that his/her participation is important and valued. Mention that the provider will be asked for separate consent after the study has been explained by the project staff.

D. The mother feels the caregiver would be reluctant to have an "outsider" judge the quality of the caregiving environment. Explain that any observations are confidential and will only be shared with the project staff (except in cases of child abuse). If the mother inquires now or at any time if we will report back to her about the caregiving arrangement, tell her "*No, our observations are confidential, just as all the information that you give us is confidential. Of course, overall study conclusions will be shared with you and any interested caregiver.*"

E. The mother suggests that she get the provider's permission before we call. Accept her suggestion, and advise her in doing so to reassure the caregiver of the unobtrusiveness of the researcher, the importance of the study, and so on.

No contact: If the mother has not contacted the provider during the 10 days after the phone call, ask her why. If possible, use one of the following suggestions to address specific concerns:

A. The mother simply forgot to contact the provider. Emphasize that it is very important that she do this in the next day or so, in order for us to have time to contact the provider and schedule the visit. If after three contacts by the project staff the mother still has not contacted the provider, probe as to why, and follow troubleshooting suggestions below (B. and C.).

B. The mother has changed her mind about consenting to the caregiver visits.

1. If the mother seems ambivalent, probe for the reasons for her reluctance. See troubleshooting suggestions for the 3-month call to handle concerns.

2. If the mother is definite in her refusal and does not want to discuss her decision, we have a missing child care observation.

3. If the mother is willing to discuss her refusal, use the trouble shooting suggestions for the 3-month phone call. If she remains unswayed by troubleshooting suggestions, we have a missing child care observation.

C. The mother suggests that we make the initial contact ourselves. We agree to do this and follow provider contact procedures.

X. PRIMARY CHILD CARE ARRANGEMENT: DECISION RULES

Each site is provided with two copies of this page summarizing the decision rules. Post a copy by each phone from which the 13 and 23-month calls will be made.

PRIMARY CHILD CARE ARRANGEMENT:DECISION RULES

Child must be in the primary arrangement 10 hours a week or more (Q32), typically awake for 3 hours on days used (Q33), and must have been enrolled for at least 2 weeks prior to the child care visit (Q36 gets age in months when enrolled. We will confirm the 2-week requirement when the child care visit is scheduled).

If mom cares for child at home (Q19[1]), other non-sibs who live in another household must be present 20 hours per week (YES to Q20, Q21, and Q22).

If mom takes child to work (Q19[2]), she must work in a child care center (Q23[1]) or another adult must regularly spend 10 hours per week with baby as a sitter (YES to Q25).

When multiple arrangements meet these criteria: (Use these decision rules hierarchically.)

1. Use arrangement with most hours of care per week (see Q32), including only those arrangements where child is typically awake for at least 3 hours.
2. If comparable hours (plus or minus 5 hours per week), use most "formal" arrangement: group program, home-based program, non-relative, relative other than father, father (see Q26).
3. If comparable hours in same type of arrangement, use arrangement in which child has been enrolled the longest (see Q36).
4. If all else is equal, use morning arrangement, unless BABY has been enrolled in afternoon arrangement for at least one month longer (see Q34).
5. If all else equal, pick primary arrangement randomly.

XI. FACE SHEET

The face sheet for the telephone contact (labeled INFORMATION FOR 13 and 23-MONTH TELEPHONE INTERVIEW) is for use by the project staff at each site to help keep track of the information needed in the interview. This sheet is not to be sent to the Data Center. It should be filed in the family's confidential file.

Before calling, fill in all the indicated information on the face sheet. Use the information collected at the most recent contact to fill in these pages. Also, use this information to fill in question 1 (Form 10C, Page 1 of the interview) before calling.

During the call, you will get information on changes in addresses, phone numbers, and contact persons. Write this new information on the face sheet.

When making calls, record the date/time and results of each call on (Form 10C) Page 3 (labeled RECORD OF CALLS). This form should not be sent to the DCC; it should be filed in the family's folder.

At the completion of the interview, fill in page 2 of form 10B completely, with date of interview, interviewer's ID number, child's ID number and relationship code, and child's age in months.

Once the interview is completed, separate the site face sheet (Page 1 of Form 10B) and the RECORD OF CALLS (Page 3 of

Form 10C) from the interview itself and file them in the family's confidential folder. Have the interview forms checked by the site coordinator or his/her designate before they are sent to the Data Center.

XII. CURRENT CHILD CARE ARRANGEMENTS GRID (Form 10A)

Before calling, have the CURRENT CHILD CARE GRID in front of you. You will fill it in as you reach Questions 26-37 in the interview. You will rely on this form to determine whether the child is in a child care arrangement that will be observed at 15 or 24 months. This is sent to the Data Center. Be sure to fill in the ID number and indicate which age (month) data is being collected..

XIII. INFORMATION SHEETS

The 13 and 23-month telephone contact packet includes several forms (INFORMATION FOR 15 and 24-MONTH LAB VISIT, INFORMATION FOR 15 and 24-MONTH CHILD CARE OBSERVER, INFORMATION FOR 15 and 24-MONTH HOME, EXPECTED CHILD CARE AT 15 and 24 MONTHS) that are designed to prepare you for the next steps in the study, whether they involve a call-back, the 15 or 24-month home visit, the 15 or 24-month lab visit, or the scheduling of a child care visit at 15 or 24 months. These are not to be sent to the data center. They can be used to notify project staff of upcoming appointments and are to be filed in the family's confidential file.

A. Child Care Observer

Before calling, have a CHILD CARE GRID and an INFORMATION FOR 15 and 24-MONTH CHILD CARE OBSERVER in front of you. For families who are not using or expecting to use child care at CHILD's 15 or 24-month birthday, you will fill in the child ID#, phone number, date/time of 13 or 23-month call, and interviewer; circle (2) for Primary child care arrangement; and record the date and time of the 15 or 24-month home visit(s) and the 15 or 24 month lab visit. For families who have a Primary child care arrangement, you complete all of this information, but circle (1) for Primary child care arrangement, and complete the information about the arrangement to be observed at 15 or 24 months.

For families who expect to be starting or changing child care when the CHILD is 15 or 24 months old, you will circle (3) for Primary child care arrangement, fill in the date and time of the call back on the RECORD OF CALLS form, and transfer the information about expected arrangements (Question 46 of the interview) to INFORMATION FOR 15 and 24-MONTH CHILD CARE OBSERVER for reference at the call back.

Finally, for those cases in which the mother wants to make the first contact with her care provider, you will need to write the date and time of the call back on Page 13, and give this call a code of (4) on the RECORD OF CALLS (Form 10C), indicating the time and date to call there as well.

B. Home and Lab Visits

INFORMATION FOR THE 15 and 24-MONTH LAB VISIT (Form 14A) AND INFORMATION FOR THE 15 and 24-MONTH HOME VISIT (Form 15A) are notification sheets to help you keep track of home and lab visit information. These sheets should be filled out after the interview and may be used to coordinate these visits at your site. They are not sent to the DCC but should be kept in the family's folder.

At 24 months, the information regarding mother's work phone and whether child care will be observed is NOT recorded on the Information for the Home Visit. The 24 month home visitor is to be kept blinded about work and child care.

XIV. AFTER THE INTERVIEW

For families who are using child care that fits our criteria for observing, one of two procedures will be followed to schedule the child care visits:

1. PREFERRED: The mother gives you permission to contact the provider directly. In this case, send the mother the letter in Appendix A2 or B2, which briefly describes the child care visit.

2. The mother first contacts the provider. In this case, you will send the materials in Appendix A3 or B3 to the mother. These are: (a) a letter to the mother which briefly describes the child care visit and tells her or him what to do with the enclosures, (b) a list of points that the mother should be sure to mention to her provider when she talks to her about participating in the study, (c) a letter to the provider that the mother may or may not choose to mail or give to the provider, and (d) an enclosure for the provider letter which describes the overall study. PUT THE LETTER TO THE PROVIDER AND THE STUDY DESCRIPTION IN A SEPARATE ENVELOPE AND ENCLOSE IN THE PACKET TO THE MOTHER.

For families who are not using child care that fits our criteria for observing, proceed with the procedures for conducting the 15 or 24-month home and lab visits.

REMEMBER

BEFORE YOU CALL:

1. Complete the INFORMATION FOR 13 and 23-MONTH TELEPHONE INTERVIEW (Form 10C, page 1)
2. Transfer all information about child care arrangements to Question 1 of the 13 or 23-month Telephone Interview.
3. Know the mother's and baby's names. If your site is participating in the HHS Fathers Study, know the father's

name and whether the parents are married (so you can use "husband" or "partner" appropriately).

4. **Tear out INFORMATION SHEET FOR 15 and 24-MONTH CHILD CARE OBSERVER and have a CURRENT CHILD CARE GRID available. You will be filling these in during the interview.**
5. **Have the decision rules for determining an observable primary child care arrangement posted by the phone and memorized.**

XV. FLOWCHART OF THE INTERVIEW PROCESS

PART 1: INTRO

PART 2: STOPPED CARE?

PART 3: SICK CARE

PART 4: CURRENT CARE

PART 5: IDENTIFY PROVIDER

PART 6: SCHEDULE HOME AND LAB VISITS

PART 7: PREPARE QUESTIONNAIRE PACKET FOR HOME VISIT

PART 8: COMPLETE INFO SHEETS FOR OBSERVER

XVI. THE INTERVIEW FORMS

The following sections of this manual provide specific information about the questions included on the phone update interview. Callers should read through this section of the manual regularly to be sure they are thoroughly familiar with all coding rules and with the format of all questions and answers.

Part 1: INTRODUCTION

This section introduces you and the interview to the mother, and obtains any updated information about addresses and phone numbers. Any changes must be recorded on the INFORMATION FOR THE 13 and 23-MONTH INTERVIEW form (Form 10C, page 1).

There are three YES/NO questions on page 1 after the introduction. They pertain to unusual changes in the child's routine, separations, and other unusual circumstances. They should have been placed on page 15, when you are scheduling the lab visit.

Part 2: STOPPED CARE?

Question 1

To link this interview to the prior 12 or 21-month phone interview, we start by inquiring about changes in child care arrangements since that contact. The interviewer should have filled in any relevant information from the Fact Sheet (Form

10C, page 1), and should be prepared to remind the mother of what she said about child care at the 12 or 21-month call.

Note that there are two options for phrasing the question, corresponding to mothers who were and were not using child care at the 12 or 21-month call. Although it seems a little awkward, the interviewer must proceed, in both cases, to ask about changes. It is possible, for example, that a mother who did not use child care when the child was 12 or 21 months old started to use care at 13 and 23 months that lasted only 1 month. In this case, she would say "yes" to Question 1.

Code "yes" if any arrangement was discontinued, even if it lasted only a very brief while.

Question 2

See Question 26.

Questions 3 and 4

See Questions 30 and 31.

Question 5

See Question 32. In cases where the hours changed in the time this arrangement was used (e.g., gradual shifting from part-time to full-time care), use the most recent hours.

Questions 6 and 7

See Question 36.

Question 8

See Question 37.

Question 9

This question is designed to assess whether this was an anticipated and/or planned change in arrangements, or whether the mother was caught by surprise or affected by events beyond her control and thus HAD to change arrangements. ASK THE QUESTION AS WORDED. If the mother answers "yes" or "no", accept her answer, regardless of the following guidelines. If she is unsure and explains her situation then and only then should you use the decision rules, below, that defines "planned" vs. "unplanned". The bottom line is to go with the mother's perception of the change as planned or unplanned. Here are some examples and guidelines for cases where the mother cannot tell you if the change was planned or unplanned. If a family day care provider stops providing care, for example, this would not be a planned change. If, however, the mother decides that she does not like the provider and therefore chooses to leave, this is a planned change. Other examples of unplanned changes include, the child is asked to leave an arrangement (some centers will not tolerate "disruptive children"), the family moves to a distant part of town unexpectedly, or another child joins the child care whom the mother dislikes and therefore she changes arrangements. Other examples of planned changes include switching from a grandparent to a center so the child can have more social interaction, changing arrangements because something more convenient or affordable is found, or changing because a friend has a baby and she decides to share care.

Part 3: SICK CARE

Ask the questions in this section only if the child was in some form of child care at the 12 or 21-month call. You can determine this from the Face Sheet (the mother indicated a child care arrangement at the 12 or 21-month call).

Questions 10 and 11

When a baby is sick, mothers often have to piece together a patchwork of care. Record one or two emergency arrangements the mother made. Question 10 has been reworded from the 5-month call which asked if CHILD had been sick on a day when the mother worked or was in school. Since mothers may use child care for any reason, we really want to know if the CHILD has been sick when the mother typically relies on child care for any reason.

Question 12

PLEASE REWORD this item to read, "In the last 2 months, have you or your (husband/partner) missed work, school, or another regularly scheduled activity because of a problem with your child care arrangement?"

Missing work means a significant amount of work. Code Yes if one parent missed a half day or more, or missed an important work obligation, such as an important meeting or appointment.

Question 13

Ask as an open-ended question and code if possible. Read the list of possible problems if the mother does not immediately volunteer a codable response. Only ONE response is allowed.

Part 4: CURRENT CARE

This section obtains information about the family's current reliance or lack of reliance on child care. Families who are using child care will fall into two groups: (1) those for whom at least one arrangement meets the decision criteria for observing the child in care at 15 or 24 months, and (2) those for whom none of the arrangements used meet the decision criteria. Recall that we are collecting the child care information on both types of families.

This is also the section where the CURRENT CHILD CARE GRID is completed (see Questions 26-37).

Question 14

The major purpose of this interview is to get information about the family's regular child care arrangements. Regular means that the mother has some standing arrangement with another person to care for the child at a specified time every week. This may include short periods of babysitting. For example, if the mother has a regular evening or Saturday afternoon when her husband/partner is expected to be responsible for the baby, this is a regular arrangement. Also, if the mother leaves the baby with her mother every Thursday afternoon, or expects an older sibling to be responsible for the baby from 4:00 to 5:00 every day, these count as regular arrangements. If she occasionally hires a sitter to go out in the evening, this is not a regular arrangement. Nor are arrangements that occur on a non-weekly basis. For example, if a mother-in-law comes one week a month to care for the child, we are not considering this to be child care. Be careful not to confuse regular with the criteria for scheduling a child care observation. It is entirely possible for a family to have a regular arrangement that does not fit the criteria for observing. For example, a sitter who comes 2 days a week for 4 hours each day does not meet the minimum of 10 hours a week for scheduling an observation.

Question 15

PLEASE REWORD this item to capture the following periods of time:

For 15 months, 14-16 months

For 24 months, 24-25 months

For 36 months, 35-37 months

You should say, "Do you expect to start using regular care (to be working for pay or going to school) between your child's 14 and 16 month birthdays?

Because we are calling the families at 13 and 23-months, but making our child care observations at 15 and 24-months, it is possible that a few families will be starting child care between this call and the child's 15 or 24-month birthday. This question is designed to flag these families, and is asked only if the family is not currently using child care (NO to question 14). If the mother responds "yes" to this question, skip to Question 46, which gets information about her child care plans, and then SCHEDULE A CALL-BACK in approximately 3 weeks.

Question 16

Some mothers may not consider themselves to be using regular child care and so answer "no" to question 14. But, in fact, they are working or going to school, in which case we want to know what they are doing about child care. If a "yes" answer is given, skip to question 18 (hours of work/school) and then inquire about child care (question 19).

Question 17

PLEASE REWORD this item to capture the following periods of time:

For 15 months, 14-16 months
For 24 months, 24-25 months
For 36 months, 35-37 months

You should say, "Do you expect to start using regular care (to be working for pay or going to school) between your child's 14 and 16 month birthdays?

This is similar to Question 15. Some mothers will resume work between their child's 13-(23) and 15-(24)-month birthdays, but will still answer "no" to question 15. This question assures that we will get information about how they plan to handle child care if they are returning to work in the next month. Again, if the mother responds "yes" to this question, skip to Question 46 and then SCHEDULE A CALL-BACK in approximately 3 weeks.

Question 18

This question is asked only of mothers who do not respond "yes" to question 14, but indicate that they are working now or going to school (Question 16). If the hours per week vary from one week to the next, ask the mother how many hours she worked or went to school "last week".

Question 19

This question is asked of mothers who did not say "yes" to having a regular child care arrangement (Question 14), but who are now working or going to school ("yes" to Question 16). Ask this as an open-ended question. The mother may respond with a non-maternal child care arrangement, such as "My husband takes care of the child." Code this as "3 Other" and complete Question 26. Similarly, the mother may say, *"Oh, my mom comes over and watches CHILD."* Code this as "3 other" and complete Question 26. But, the mother may indicate that she takes care of the baby while she is working and would have probably said "no" to Question 14. If this is the case, two options are possible. The mother may work at home and care for the child at the same time (code as "1" and GO TO Question 20). This will be the case for mothers who provide family day care in their own home, as well as for mothers who are, for example, private consultants and who work out of their home and decide not to hire anyone else to provide child care. Alternatively, the mother may take the child to her out-of-home job and either watch the child full time or rely on someone at the worksite to watch the child at least part time (code as "2" and GO TO Question 23).

Questions 20, 21, and 23

If the mother is taking care of her child while working/studying at home, the three conditions described in questions 20, 21, and 23 MUST BE MET before we will observe this arrangement as a child care arrangement. Specifically, unrelated children (Q20), who live in another household (Q21), must spend at least 20 hours per week with the mother and child in a typical week (Q23) for us to observe this as a child care arrangement. A response of "no" to any of these questions ends the interview and you move to scheduling the 15 or 24-month home and lab visits. It is important to note that some children will have siblings who live in a different household and who come to the mother's house during the day. We will NOT observe these arrangements, because we consider mother and siblings to be a primary family unit. However, if the child has a cousin who lives in a different household and comes to the mother's house during the day (20+ hours per week), we DO observe this arrangement. Basically, we consider these mothers to be family day care providers.

Questions 23, 24, and 25

If the mother takes CHILD to work with her, we will observe this as child care IF the mother is a child care worker and CHILD comes to her center (Q23[1]) OR the mother has another form of employment (Q23[2]) in which she brings CHILD to work, but some other adult routinely watches CHILD for 10 hours a week while the mother is doing other things ("Yes" to Q25).

If the mother is a child care worker, we find out if CHILD is in her classroom (Q24). If she answers "yes", GO TO question 26 and, working with the GRID, ask if anyone else takes care of CHILD. There may be more than one child care provider for the infant classroom, for example, in which case you would code 0) mother and 7) unrelated adult (assuming the provider is unrelated) for 26. If she answers "no", GO TO question 26 and ask as worded: Who takes care of CHILD? Obviously, in both of these cases, you can code 27 as 3 and 28 as F, but 31 will vary depending upon whether only the mother, only another provider, or both provide care.

If the mother brings CHILD to work and another adult watches CHILD for 10+ hours per week (even if it is the father), GO TO question 26 to find out who this other adult is and whether he/she lives in the child's home or not. You can code 27 as "4". If the mother brings CHILD to work and the criterion for observation is not met (no other adult watches the baby for 10+ hours per week), then the interview is completed and you need to schedule the 15 or 24-month home visit.

USE OF THE GRID (Questions 26-37)

The interviewer will have the grid placed in front of him/her. All responses to Questions 26-37 are recorded on the grid. This will greatly facilitate the process of determining whether the child is in an arrangement that meets the criteria for observing at 15 or 24 months and, in the care of multiple arrangements, which one to observe. For families with one observable arrangement, the interviewer should also complete the GRID section of the INFORMATION SHEET FOR CHILD CARE OBSERVER.

Question 26 and 27: Coding Child Care Arrangements

You will obtain this information by asking open-ended questions: Who is caring for the child? You will need to probe after the mother gives you one arrangement, to make sure that she is not forgetting to tell you about additional arrangements.

Mothers will answer the questions about child care arrangements with more conventional descriptions (babysitter, nanny, etc.). The responses on the interview form are not intended to be read to parents. Instead, they are for your use in coding the type of arrangement the parents have made for child care. Thus, if the mother says they have found a sitter, you will need to ask if the sitter is a relative, whether he or she will be coming in to their home or they will be taking CHILD to the sitter's home, and whether the sitter lives in the child's home or elsewhere.

Be sure to code all arrangements, even if some of them are informal, such as the child's father staying home until 9:00 every morning. Although many mothers will not think of this as a child-care "arrangement", it is to us. Use Arr. 1 for the arrangement used for the most hours, Arr. 2 for the next, and Arr. 3 for the third. Do not code more than three arrangements.

If the mother begins to tell you about future plans, explain that we will be asking about this at the end of this interview (see Question 45).

It is a good idea, in the case of multiple arrangements, to let the mothers describe the situations and code the information while she is talking. Then go back and confirm the information and fill in any gaps before proceeding.

Sometimes it will be difficult to determine whether a particular situation is one or two arrangements. For example, if CHILD has a non-related sitter who comes into the child's home 3 days a week and cares only for CHILD, and who takes CHILD along with her to a different child's home for 2 days a week (thus caring for two children on these two days in the other child's home), this counts as two arrangements, as follows:

Arrangement 1: WHO? = 7) Unrelated adult
WHERE? = 1) In baby's home
LIVE IN? = No

Arrangement 2: WHO? = 7) Unrelated adult
WHERE? = 2) In someone else's home
LIVE IN? = No

This counts as two arrangements, because you are not able to give more than one response for #27 WHERE? and, therefore, could not accurately code the relevant information as one arrangement. It is also important to code this as two arrangements because you will have two different responses for Question 30 (Arrangement 1 = 00; Arrangement 2 = 01).

Similarly, the CHILD may be cared for alone by a sitter on Monday and Wednesday at the baby's home, but be joined by her 3-year-old sister on Tuesday and Thursday. Again, this would count as two arrangements, both coded as WHO? = 7, WHERE? = 1, LIVE IN? = No, but coded as 00 and 01 for Question 30.

It is also possible that some mothers who use their husbands/partners for child care will say "no" to Question 14, "yes" to Question 16, and will indicate for Question 19 that the husband/partner helps her with child care while she works (thus, Question 19 gets coded as (3) and you skip to Question 26). GO BACK TO Question 14 and score YES. You may then restate Question 26 as a statement: *"CHILD's father/your partner will care for CHILD. Where will they be? Does he live in CHILD's home?*

Examples of probe questions to ask:

Mother's Response	Query
"My neighbor is caring for CHILD.	1) *"Is your neighbor related to you?"*
	2) IF NO, code 6 for Q26.
	3) IF YES, *"What relation?"*

	4) *"Is CHILD cared for at your neighbor's house?"* 5) IF YES, code 2 for Q27. 6) IF NO, *"Where is CHILD cared for?"* 7) *"Does your neighbor care for CHILD during all the hours you work?"* 8) IF NO, *"What other child care arrangement do you use?"*
"My church has a nursery that I use."	1) *"Who cares for the children in the nursery?"* 2) *"Is the nursery open during all the hours you work?"* 3) IF NO, *"What other child care arrangement do you use?"*
"My husband is taking time off when I'm working."	1) *"Does he care for CHILD at home?"* 2) *"Is he able to care for CHILD during all the hours you work?"* 3) IF NO, *"What other child care arrangement will you use?"*
"I've hired a nanny."	1) *"This is someone who comes to your home to care for CHILD?"* 2) IF NO, *"Where is CHILD cared for?"*

3) *"Is this person related to you?"*

4) IF YES, *"What relation?"*

5) *"Will the nanny live in your home?"*

Questions 28 and 29

For families using child care that is not observed, Question 28 is the only source of data about gender of the caregiver. Obviously, you will use confirmatory language if you know the father or grandmother provides child care. Question 29 enables us to distinguish nannies from out-of-home providers.

Questions 30 and 31

Some mothers, particularly those who use group care, will tell you that they don't know how many other children are in the classroom, or how many people supervise her child. Ask her for an estimate. If she says she has no idea at all, leave this question blank.

The purpose of these questions is to find out how many other children are usually present when the child is in the care setting, and how many regular caregivers the child has. In a day care center record the number of children in the child's group or classroom, not the number in the whole center. In both centers and homes, the number may change during the day. Ask the mother for the typical number present during the majority of the time the child is in the setting. For example, if three kindergarten children are cared for by the child's caregiver from 4 p.m. on, but the target child is cared for from 8:00 to 5:00, do not count these children as part of the typical group. Base the typical group on the current situation; group sizes will also change seasonally.

In counting caregivers, ask the mother for the number of different people who supervise the children on a regular basis. For example, if the child's group has a head teacher who is present all day, two assistants in the morning and two different assistants in the afternoon, the number of people supervising the children is five. If a home child care provider has a teenager or another adult who regularly assists with the children, and the caregiver's husband is in charge everyday after 4:30, the number of people supervising the children is three. Don't count music teachers, etc., who come in two times a week.

Remember that we will actually observe staff-child ratios over the course of the child care visit at 15, 24, 36 months. The responses to these questions will not serve as estimates of staff-child ratios.

Questions 32, 33, 34, and 35

These questions are intended to get at the pattern of child care as well as the total number of hours. Thirty hours divided over 3 days is a different experience for the child than 30 hours divided over 5 days. In cases where the baby's schedule changes from week to week, ask the mother for the "most typical" situation in her opinion. We will obtain more detailed information about schedules when we do child care visits. If the word "arrangement" is awkward for the situation of the family you are interviewing, reword Question 32 to say, for example, "*How many hours a week (is CHILD/will CHILD) be cared for by your mother?*"

Question 33 is important for the determination of whether to observe CHILD in child care. If the mother says "it varies a lot", you can ask specifically if CHILD is awake 2 days a week for 3 hours a day. This will make the observations feasible. If you get an indication that you cannot count on this amount of awake time, then mark "no", and it is not an arrangement that we will observe.

For Question 34, you can mark more than one response. For example, if CHILD is in a day care center from 7 am to 6 pm every day that this center is used, then code 1 and 2 for this arrangement. If, however, CHILD goes to the center in the morning on some days and in the afternoons on others, then code as 5. Thus, "times vary" means that, for a single arrangement, the hours that CHILD spends in this arrangement are not consistent from one day to the next over the course of a week.

For Question 35, count a portion of a day as a day.

Question 36

Get the mother's best estimate if she cannot remember.

For responses in days or weeks, round up to months, e.g. 6 weeks = 2 months.

Question 37

Ask this as an open-ended question. If the mother's response clearly fits one category (e.g. *"I really wanted CHILD in her own home"* = 8), code it as such. If it could fit several categories, read the relevant categories and ask the mother to choose one (e.g., *"Only someone like Granny could really take good care of CHILD."* Ask, *"So would you say the quality of the care provider is the most important reason, or that your preference for a relative to provide care is the most important reason?"*). If the mother gives more than one answer that fits more than one category, you'll need to ask her to give you one response. Say, "*What would you say was the most important reason?*" Write in what the mother says if you code her answer as 11) Other.

Skip questions 38-41 if mother is an in-home child care provider.

Question 38

If the mother pays a daily or monthly rate, record what she tells you and later calculate a weekly rate. Do not take up interview time to make these calculations. If the mother has one or more arrangements that you think may be free (father or grandmother, for example), you can phrase the question more as a confirmation: *"And our next question is how much you pay for this care."* Mothers will typically let you know if there is no cost. If they are not paying, record 00. If the mother is using multiple arrangements over the course of a week, but gives you a weekly rate, ask her to give you the amount she pays each week for each arrangement.

Question 39

If mothers are not paying for care, rephrase Question 39 as: *"Does this care include other children of yours?"*.

Question 40

Be sure to count children other than CHILD.

Question 41

Be sure to get information only on current support. If you know the parent is receiving free or very low cost care (from Question 38), you can confirm that situation. Responses 2, 4, 6 and 8 refer to "low-cost or free" care. Low-cost, in this context, means that the child receives subsidized care so that the parents are not paying the full cost. Some parents do not pay anything for child care. They get free care because they are fully subsidized by a government program (#2) , by their employer

(#4), or by an agency (such as a social services agency) (#6). In other cases, a relative or friend of the child will provide child care free of charge. In these cases code #8. Also, use response [8] for a family who has worked out a cooperative child-care sharing arrangement with another family and so are not paying for care. Response [3] includes mothers who are child care providers in centers that offer free or reduced-fee care to their staff. Response [7] indicates that a relative or friend is providing money to pay for child care.

If parents reply that they receive no financial help, ask, "Do you plan to claim a tax credit for child care expenses?" If the mother says yes, record the response as [9]. Some states, as well as the federal government , offer these tax credits/deductions for child care. Some mothers may say that they receive no financial help and they are not claiming a tax credit, but their employer is allowing them to set aside up to $5,000 of her taxes before income to help pay for child care. These Dependent Care Assistance Plans are becoming increasingly common. The money that is set aside does not count as taxable income, therefore this is a form of tax subsidy for child care. Code this as [9]. Option #10 is coded when the family pays the full cost of care (no tax credit or deduction issued).

Questions 42 and 43

These questions are designed to measure the mother's satisfaction with her current child care arrangement -- not the generic type of arrangement, but the specific provider(s) that she is now using. Read the responses and ask the mother to choose ONE. For Question 43, if she says that she would not recommend to her friend that she use her provider because she does not want to share care, explain that you want to know how satisfied she is with her current arrangement, and this is one way of asking this -- you don't mean to imply that she would have to share care.

If the child is receiving care from a relative or close friend, particularly the father, this is a difficult set of questions, particularly for Question 43. In these cases, it is fine to say, "*Based on your experience, what would you say to a friend who wanted to make the same type of arrangement that you have made.*"

Question 44

Write down whatever the mother says.

Questions 45 and 46

PLEASE REWORD this item to capture the following periods of time:

For 15 months, 14-16 months

For 24 months, 24-25 months

For 36 months, 35-37 months

You should say, "Do you expect to start using regular care (to be working for pay or going to school) between your child's 14 and 16 month birthdays?

These questions will tell you if you need to schedule a call-back because the child will be in a different child care arrangement when she/he is 15, 24, 36 months old. For Question 46, see Question 26, 27, and 29, with the addition of a "don't know" code.

Part 5: IDENTIFY PROVIDER

At this point in the call, you need to determine whether the target child is in an observable child care arrangement. Some children will be in care that is not observable. You will work with the GRID and the INFORMATION SHEET FOR CHILD CARE OBSERVER for this portion of the call.

Recall that the arrangement may be made for any reason. The mother does not have to be employed or in school.

There are two basic criteria that must be met in order for a child care arrangement to be observable:

(1) The child must be in care 10 hours a week or more

(2) The child must be awake for 3 hours on a typical day in care in order to make the observation feasible

You will work with the GRID to determine whether any arrangements meet these criteria (see question 32 and 33), and, if so, how many of them meet the criteria.

Once you have determined the primary arrangement, you will ask the mother a series of questions while completing the INFORMATION SHEET FOR CHILD CARE OBSERVER.

Children With One Observable Arrangement

For children with one observable arrangement, this becomes the primary arrangement. You will pick up with the script, saying "As we've told you, we'd like to see CHILD is (his/her) childcare when he/she is about (15/24) months old. We would like to visit (PROVIDER: GIVE ALL IDENTIFYING INFORMATION, E.G., WHO AND WHERE FROM GRID).

You then obtain information about the name of the provider (or of the center), address, and phone numbers.

Next, you will ask when the child started using the arrangement. THIS IS IMPORTANT FOR SCHEDULING SINCE THE CHILD MUST HAVE BEEN IN THE ARRANGEMENT FOR 2 WEEKS PRIOR TO THE FIRST OBSERVATION. It does not have to be full time for 2 weeks, just 2 calendar weeks since initial enrollment.

Then you will ask about the hours each day when the child is in the primary arrangement and fill in the actual hours on the INFORMATION SHEET FOR CHILD CARE OBSERVER.

The final step involves determining whether you can contact the provider directly and, if not, making arrangements for the mother to contact the provider and for you subsequently to re-contact the mother.

For Children with Multiple Observable Arrangements

When multiple arrangements meet the two criteria for observable child care, you will need to determine which one is the primary arrangement for purposes of observation. There are five guides, which should be approached hierarchically:

(1) Use arrangements with the most hours of care per week including only those arrangements where the child is typically awake for at least 3 hours. There is one exception to this first guide. If father care is the arrangement with the most hours and there is another observable arrangement, the other arrangement will be the primary arrangement. We will observe father care only if there is no other observable arrangement.

(2) If comparable hours (plus or minus 5 hours per week), use most "formal" arrangement; in this order: group program, home-based program, non-relative, relative other than father, father.

(3) If comparable hours in same type of arrangement, use arrangement in which the child has been enrolled the longest.

(4) If all else is equal, use morning arrangement, unless the child has been enrolled in the afternoon arrangement for at least one month longer.

(5) If all else is equal, pick the primary arrangement randomly.

Once you have determined the primary arrangement, follow the procedures outlined above under Child with One Observable Arrangement.

Special Cases

There are two special cases that count as observable care and must be considered when determining the primary arrangement.

(1) The mother cares for the child at home (Question 19[1]) AND other non-sibs who live in another household are present 20 hours per week (YES to Questions 20, 21, and 23).

(2) The mother takes the child to work (Question 19[2]) AND:

  (a) She works in a child care center (Question 23[1]). (She may or may not have her child in her classroom.)

  OR

  (b) Another adult regularly spends 10 hours per week with the baby as a sitter at the mother's workplace (YES to Question 25). In this case, it must be one adult spending 10 hours or more with the child. If there are two adults who each take care of the child for 5 hours per week, this is NOT an observable arrangement. If there are two adults who each take care of the child for 10 hours or more per week, select the provider based on the criteria listed for multiple arrangements (i.e., most awake hours, provider child has known the longest, morning provider, random choice).

Part 6: SCHEDULE HOME AND LAB VISITS

This is a very important part of the procedures for the 15- and 24-month assessments. The home and lab visits may be scheduled at the conclusion of the 13- and 23-month calls, as planned. However, they may also be made in separate calls. In this latter case, it is important to use the language in the following scripts when describing the content of the various home and lab visits. The scheduler needs to describe briefly both visits and set up the dates and times for these visits (see windows and ideal times, below.)

15 Month Lab Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Home Visit	The Week Before the Lab	15 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
15 Month Child C. Visit	The Week Before 15-Months	14 Months, 0 Days to less than 16 Months, 0 Days	16 Months, 0 Days to less than 19 Months, 0 Days
24 Month Lab Visit	24-Months 7 days	24 Months, 0 Days to less than 26 Months, 0 Days	26 Months, 0 Days to less than 29 Months, 0 Days
24 Month Home Visit	24-Months 0 days	24 Months, 0 Days to less than 26 Months, 0 Days	26 Months, 0 Days to less than 29 Months, 0 Days
24 Month Child C. Visit	24-Months 7 days	24 Months, 0 Days to less than 26 Months, 0 Days	26 Months, 0 Days to less than 29 Months, 0 Days

Rules of thumb for scheduling the visits:

1. The home visit should precede the lab visit, unless this is logistically impossible (e.g., cancellations). This is very important and you should change this order only if you risk losing a visit.

2. Because of difficulties scoring strange situations on older toddlers, the 15-month lab visit should be conducted as close to 15 months as possible.

3. The child must be awake, alert, and healthy for the lab visit. There should also not be any unusual separations from the mother in the previous week. The child should NOT have changed child care in the two weeks prior to the lab visit. Moreover,

avoid scheduling the lab visit after the mother has picked the child up from child care, after a lengthy shopping trip, or any other stressful event. The mother and child should be together for at least two hours prior to the lab visits. This is particularly crucial for the 15-month lab assessment of attachment.

4. At 15 months, the child must be awake and alert for at least part of the home visit. At 24 months, the home visit will involve a 2 hour observation to complete the Attachment Q-Set. In general, allowing time for greeting the mother, taping or observing the mother, questioning the mother, distributing the MacArthur Language Inventory, and giving the mother information for the lab visit, the visitor will be in the home for 2 1/2 - 3 hours. That amount of time should be scheduled with the mother.

The scheduling of the 24 month home visit must be done very carefully with several concerns in mind:

First, the mother must know that we have to have a time when the child will be awake and rested (and healthy) for the full two hours. If the child is asleep when we arrive or goes to sleep, it will either lengthen this visit or result in the need for a second visit.

Second, we prefer a time when mother and child (and younger sibling) only are in the home. It is much harder to do the visit if the father and older siblings are present, and we MUST avoid observing most nonemployed mothers with only mother and child present while observing most employed mothers with whole families present. Therefore, we need to make extra effort to schedule when just mother and child and younger siblings, if any, are home. However, we don't wish to ask the impossible of families. Find out if there is a normally occurring time when just mother and child (and younger sibling) are home when we can come and then schedule for that time. If those times prove impossible, find out if there is a time when it would be convenient for just mother and child to be in the home. If there simply is not, then schedule for a time when father and/or older siblings are home. The observation CANNOT be done if other children who don't live in the home are there. Make sure that the mother knows that she should be in the home for the full two hours of observation, while the father and older siblings can come and go if they wish.

After the phone call, a confirmation letter should be sent (see Appendixes A and B). This letter should include the dates and times of the visits.

Please use the following descriptions of the home and lab visits when scheduling these visits. They are slightly revised from what is on the scantron forms.

SCRIPTS

"Now, the last thing I need to do is schedule our visit to your home and your visit to our playroom when CHILD is ____(15,24) months old. You may remember that at ____(15,24) months we will need to see you in your home and also at our children's playroom at [SITE LOCATION]. I would like to ask you a few questions and tell you a little bit about these visits. (Ask 3 questions on page 1 and code answers.)

AT 15 MONTHS:

The home visit will take about 2 hours and will be similar to the Six Month Visit. We will ask you a few questions, like we did before and ask you to fill out some of the same questionnaires. We will also videotape you and CHILD together for about 15 minutes. CHILD will obviously need to be awake for this part of our visit. We will also leave a questionnaire with you to complete and then bring along when you come to visit our playroom.

AT 24 MONTHS:

The home visit will take about 2 1/2 hours. In general we will spend our time observing you and CHILD as you go about your normal activities around the house. We want you to do what you typically would be doing at this time of day. We need to make sure that we can come when CHILD will be rested and awake for the visit. This visit should be scheduled so that there are no overnight separations from the CHILD in the week prior to the visit or any other big changes in routine. We'd prefer to see you on a day when you and your child have been together all day. If this is not possible, we'd just like to make sure that we avoid times, such as immediately following a pick-up from child care or after a lengthy shopping trip, when your child might be very tired. Also, we prefer a time when just you and CHILD (and younger sibling) are at home alone. Because it is very important to do the visit the same way for each family, we ask that fathers and older siblings are not present during this visit. Some families may not have older children and in many cases fathers are unable to be present. (We will pay for your older child/children to go to a sitter if this will help).

I know you're very busy, especially with a toddler. We'd like to pick a time for this visit that is best for you and for CHILD. Again, we will be observing you and CHILD as you go about your normal routine. This might include household chores or meal preparation or playtime, etc. When would be a good time for us to come?

ADD IF MOTHER IS EMPLOYED: Would it be helpful if we came on ________________ (suggest time outside of working hours).

ARRANGE A TIME FOR THE HOME VISIT. (should be scheduled before the lab visit) WRITE DATE AND TIME ON THE INFORMATION SHEET FOR THE OBSERVER.

Who else will be at your house during that time? (Recall that we want only mother and child, younger sibs ok) (WRITE DOWN ON INFORMATION SHEET).

Please remember that you don't need to prepare anything, and don't worry about cleaning up. We know you are very busy. We want this to be as informal as possible, and we'll be informal too. Please don't go to any trouble.

CONFIRM APPOINTMENT TIME. ADDRESS AND PARKING SPOT.

Now we would like to set up the visit to our playroom.

AT 15 MONTHS:

The playroom visit will take about 1 1/2 hours. During that time, we will observe and videotape CHILD as he/she plays with toys that we provide and during two brief separations from you. You will be able to see your child at all times, and you may return to your child whenever you like.

We will also administer a measure of developmental progress. At the end of the visit we will weigh and measure the length of CHILD and write down the weight and height for you. You may want to dress your child so that he/she can be weighed in tee shirt and diaper (or underpants). If CHILD wears heavier clothing, his/her weight will not be accurate.

AT 24 MONTHS:

The playroom visit will take about 1 1/2 hours. During this time we will watch your child play with different toys. Similar to what we did at 15 months, we will have 3 toys for you to give the child. We will also administer a measure of developmental progress. We will have time for a brief snack and then we will have about a 20 minute interview with you and ask you to complete just 2 questionnaires."

Part 7: ASSEMBLE QUESTIONNAIRE PACKET

The 23 month phone caller will assemble the Questionnaire Packet for the home visitor. The Home visitor is to be kept blinded about the current work and child care situations. After scheduling visits or at the end for the interview if another caller schedules the visit, the 23 month phone caller will need to determine if during the course of the interview it is known that the mother works for pay 10 or more hours per week. If the phone caller does not know definitely that the mother is or is not working for pay 10 or more hours per week the caller will say, "I will be putting together the packet of questionnaires which will be left with you at the home visit. To do this, I need to get some information about employment. Are you now working for pay 10 or more hours per week?" Record answer on the information sheet.

The following questionnaires should be placed in a large envelope (9 X 12) labeled with the family name and given to the home visitor who will be conducting the home visit.

- The MacArthur Communicative Inventory: Toddlers
- My Feelings (Form 15D)
- Parental Care (Form 15E)
- Relationships With Other People (Form 15F)
- Family Finances (Form 15H)
- Parent Experiences (Form 15I)

For mothers employed for pay 10 or more hours per week:

- Job Experiences (Job Stress) (From 15J)

For mothers with observable child care:

- My Child Care (Form 15K)

XVII. DEBRIEFING

Follow the script as written, being sure to give the mother a chance to ask any questions she may have. It is a good idea to make a note of any questions and what your response is, and to check with your site coordinator and/or P.I. to be sure all staff members are following the same procedures. If you are at all unsure about the answer to a question, do not try to answer it. Instead, tell the mother you will find out and call her back. Talk to the site coordinator and/or P.I. and arrange for someone to call the mother back within that same day if possible.

Conclude the interview by telling the mother when she will be contacted next and what will happen at that contact.

XVIII. APPENDICES

A. 15-month Materials

A1. Sample Letter to Send to Mother When Unable to Contact by Phone

Mother's Name
Last Known Address

Dear _________:

Thank you for agreeing to participate in the NICHD Study of Early Child Care. We have enjoyed getting to know you and BABY, and it's good to have you as part of the study.

We have been trying to contact you to find out how you and BABY are getting along. Please fill out and return the enclosed card to us, or call our offices at AREA CODE/PHONE. Feel free to call us collect. Also, you can call at any time and leave a message on our answering machine. Please let us know the best way to contact you.

We hope things are going well for you and BABY. We look forward to hearing from you soon.

Sincerely,

Project Staff Member

Enclosure: Return postcard

A2. Materials to Send to Mothers Who Let You Contact the Provider

LETTER DESCRIBING 15-MONTH CHILD CARE VISIT FOR MOTHER

Mother's Name
Last known address

Dear :

As we discussed on the phone, we will be contacting (NAME OF CARE PROVIDER) about our visit to observe CHILD [or when CHILD is at the day care center].

We want to find out what CHILD is usually like when (she/he) is in (his/her) care [or at the center], and also a little about the people caring for (him/her). To do this, someone from our staff will visit BABY's child care to watch for about three hours on two different occasions. This person will also talk to the care provider about (his/her) education and experiences in caring for children and about how your child spends the day. The care provider will also be asked to complete several brief questionnaires about your child, similar to those you have completed, and about (his/her) feelings about providing child care.

(His/Her/Their) participation in the study will be of great value. It will provide important information to help us learn more about those things that lead to healthy development for young children.

Thank you for your help.

Sincerely,

Project Staff Member

A3. Materials to Send to Mothers Who Want to Make First Contact With Child Care Provider

1. Letter describing 15-month child care visit for mother

Mother's Name
Last known address

Dear :

As we discussed on the phone, we would like you to talk to (NAME OF CARE PROVIDER) about our visiting when (she/he) is caring for CHILD [or when CHILD is at the day care center]. We have enclosed a list of points that you should be sure to mention when you talk to your provider.

We want to find out what CHILD is usually like when (she/he) is in (his/her) care [or at the center], and also a little about the people caring for (him/her). This would mean someone from our staff coming to watch for about three hours on two different occasions. This person would also talk to the care provider about (his/her) education and experiences in caring for children and about how your child spends the day. The care provider would also complete several brief questionnaires about your child, similar to those you have completed, and about (his/her) feelings about providing child care.

The care provider may be a little uncertain about the visits and want to know more about them. We have enclosed some information that you can give (him/her). Specifically, feel free to mail or give the enclosed letter from us, along with the study description, to your care provider. You can also tell (him/her) that we will be phoning to talk about the visits in more detail and to answer any questions.

(His/Her/Their) participation in the study will be of great value. It will provide important information to help us learn more about those things that lead to healthy development for young children.

Thank you for your help.

Sincerely,

Project Staff Member

Enc: Letter to Care Provider
Study Description for Care Provider
List of points to mention to the provider

BE SURE TO MENTION TO YOUR PROVIDER that...

1. You have given your permission for your child to be visited at child care.

2. You have been in the study since your child's birth and (we sincerely hope) have enjoyed the experience.

3. All information that is gathered on the child and the child's child care is kept strictly confidential. This information we gather during our visits will only be shared with project staff. No one will be named in any reports of the study. All information is kept in locked files at the site.

4. We need the provider's permission, in addition to yours, to visit the child at child care.

5. We are not going to evaluate the child care provider or setting. We just need to learn about where and how the child spends his/her days.

6. Someone from the study at the site will be calling them in the next few days to describe the child care visit in detail and to answer any questions.

7. We will pay the provider $40 for his/her participation.

8. You hope she/he/they will participate.

A4. Letter for mother to send to her provider

Dear ____(NAME OF PROVIDER)__________,

As you may already know, ____(MOTHER)_____, and her child, ___(CHILD)___ are taking part in an exciting and important study called the NICHD Study of Early Child Care. They have been in the study since the CHILD was born.

The major aim of the study is to learn how the different people, places, and events in the lives of young children affect their development. We have attached a one-page description of the study for you to read and even to post if you would like.

As part of the study, we need to see ______(CHILD)______ in his/her child care setting since this is such an important part of his/her early life. We would like to come and ________(CHILD)___, when she/he is with you. _____(MOTHER)_____ has given us their permission to do this. We will pay you $40 for your participation.

We know you are busy, and we will arrange our visits at times convenient to you. We will also respect the routines and responsibilities of the caregiver(s) during our visits. We want to see what the child is usually like when she/he is with you. We would just watch whatever the child typically does and ask some questions about how she/he usually spends the day. We would also ask you some questions about your own education, child care experiences, and feelings about providing child care.

Your participation in the study will provide valuable information which will help all of us learn more about young children's development. All of this information will be kept strictly confidential. We will be calling you to tell you more and to answer any questions that you may have about the study.

Sincerely,

Project Coordinator

Enc: Study Description

A5. Description of study

THE NATIONAL INSTITUTE OF CHILD HEALTH AND DEVELOPMENT

STUDY OF EARLY CHILD CARE

Children born today will be growing up in a world different from that of their parents. How will growing up in the 1990's affect children's development? To answer this most important question for America's future, the National Institute of Child Health and Human Development has funded the NICHD Study of Early Child Care.

The NICHD Study of Early Child Care is being conducted at ten different sites in the United States. The main aim of the study is to learn about the variety of people, places, and events that children experience in their early years and the many pathways that lead to healthy development. Aspects of development that will be studied include social, language, cognitive, and health outcomes.

Families become involved in the study on a voluntary basis soon after the infant's birth. Several times during the three years that the families are involved in the study, the children, their parents, and other caregivers will be observed and interviewed. Parents are asked to describe their views about childrearing, their feelings about working and parenting, and their perceptions of the child's personality and behavior. Because child care outside the family is also an extremely important setting in which children grow and change, caregivers are asked to participate as well. Summary results will be available to all study participants at the conclusion of the project in 1995.

VISITS TO CHILD CARE SETTINGS

Each child is the study is visited in his or her care setting on two different days, when he or she is 6, 15, 24, and 36 months of age.

At the first visit, a staff member observes the child for about 3-4 hours. She tries not to interfere with the usual routine in the child's room. At the end of the visit, she leaves 4 questionnaires for the child's caregiver(s) to fill out before the second visit. These questionnaires contain questions about the caregiver's education and experience. This should take no more than 20 minutes of the caregiver's time, and the staff members work around the schedule and routines of the caregiver(s).

At the second visit, the staff member again observes the child for about 3-4 hours. Then, she talks to the caregiver(s) briefly about the child's activities and about the caregiver's education and experience. Again this should takes no more than 20 minutes of the caregiver's time, and the staff member will be considerate of the caregiver routines and responsibilities.

Because we want to see what usually happens when children are in child care, we try to make our visit interfere as little as possible with the caregiver's routine.

The results of this study will not only guide policy makers, but will also be of more immediate use to parents and child care providers as they engage in the rewarding, but challenging, responsibility of rearing young children.

A6. Sample Appointment Letter for 15-Month Home Visits

Date

Name
Last known address

Dear :

This letter is to confirm the appointment that we made. I will be visiting with you at your home on (day of week, month, date, time).

We would like you to bring CHILD to our playroom at the University on (day of week, month, date, time). We will give you directions to the playroom and a parking permit before your visit.

Please remember to bring along the completed Version of the MacArthur Communicative Development Inventory, which we gave to you during the home visit. If you have any questions or problems with the form, we will be able to go over them at the time of the lab visit. Thank you for taking the time to give us this valuable information!

Please feel free to contact me at (608) 263-1565 or 263-1662 if you have any questions or concerns. I look forward to visiting with you.

Sincerely,

NAME
NICHD Study of Early Child Care

B. 24-month Materials

B1. Sample Letter to Send to Mother When Unable to Contact by Phone

Mother's Name
Last Known Address

Dear __________:

Thank you for agreeing to participate in the NICHD Study of Early Child Care. We have enjoyed getting to know you and BABY, and it's good to have you as part of the study.

We have been trying to contact you to find out how you and BABY are getting along. Please fill out and return the enclosed card to us, or call our offices at AREA CODE/PHONE. Feel free to call us collect. Also, you can call at any time and leave a message on our answering machine. Please let us know the best way to contact you.

We hope things are going well for you and BABY. We look forward to hearing from you soon.

Sincerely,

Project Staff Member

Enclosure: Return postcard

B2. Materials to Send to Mothers Who Let You Contact the Provider

LETTER DESCRIBING 24-MONTH CHILD CARE VISIT FOR MOTHER

Mother's Name
Last known address

Dear :

As we discussed on the phone, we will be contacting (NAME OF CARE PROVIDER) about our visit to observe CHILD [or when CHILD is at the day care center].

We want to find out what CHILD is usually like when (she/he) is in (his/her) care [or at the center], and also a little about the people caring for (him/her). To do this, someone from our staff will visit BABY's child care to watch for about three hours on two different occasions. This person will also talk to the care provider about (his/her) education and experiences in caring for children and about how your child spends the day. The care provider will also be asked to complete several brief questionnaires about your child, similar to those you have completed, and about (his/her) feelings about providing child care.

(His/Her/Their) participation in the study will be of great value. It will provide important information to help us learn more about those things that lead to healthy development for young children.

Thank you for your help.

Sincerely,

Project Staff Member

B3. Materials to Send to Mothers Who Want to Make First Contact With Child Care Provider

1. Letter describing 24-month child care visit for mother

Mother's Name
Last known address

Dear :

As we discussed on the phone, we would like you to talk to (NAME OF CARE PROVIDER) about our visiting when (she/he) is caring for CHILD [or when CHILD is at the day care center]. We have enclosed a list of points that you should be sure to mention when you talk to your provider.

We want to find out what CHILD is usually like when (she/he) is in (his/her) care [or at the center], and also a little about the people caring for (him/her). This would mean someone from our staff coming to watch for about three hours on two different occasions. This person would also talk to the care provider about (his/her) education and experiences in caring for children and about how your child spends the day. The care provider would also complete several brief questionnaires about your child, similar to those you have completed, and about (his/her) feelings about providing child care.

The care provider may be a little uncertain about the visits and want to know more about them. We have enclosed some information that you can give (him/her). Specifically, feel free to mail or give the enclosed letter from us, along with the study description, to your care provider. You can also tell (him/her) that we will be phoning to talk about the visits in more detail and to answer any questions.

(His/Her/Their) participation in the study will be of great value. It will provide important information to help us learn more about those things that lead to healthy development for young children.

Thank you for your help.

Sincerely,

Project Staff Member

Enc: Letter to Care Provider
Study Description for Care Provider
List of points to mention to the provider

BE SURE TO MENTION TO YOUR PROVIDER that...

1. You have given your permission for your child to be visited at child care.

2. You have been in the study since your child's birth and (we sincerely hope) have enjoyed the experience.

3. All information that is gathered on the child and the child's child care is kept strictly confidential. This information we gather during our visits will only be shared with project staff. No one will be named in any reports of the study. All information is kept in locked files at the site.

4. We need the provider's permission, in addition to yours, to visit the child at child care.

5. We are not going to evaluate the child care provider or setting. We just need to learn about where and how the child spends his/her days.

6. Someone from the study at the site will be calling them in the next few days to describe the child care visit in detail and to answer any questions.

7. We will pay the provider $40 for his/her participation.

8. You hope she/he/they will participate.

B4. Letter for mother to send to her provider

Dear ____(NAME OF PROVIDER)________,

As you may already know, ____(MOTHER)____, and her child, ___ (CHILD)___ are taking part in an exciting and important study called the NICHD Study of Early Child Care. They have been in the study since the CHILD was born.

The major aim of the study is to learn how the different people, places, and events in the lives of young children affect their development. We have attached a one-page description of the study for you to read and even to post if you would like.

As part of the study, we need to see ______(CHILD)______ in his/her child care setting since this is such an important part of his/her early life. We would like to come and ________(CHILD)___, when she/he is with you. ______(MOTHER)_____ has given us their permission to do this. We will pay you $40 for your participation.

We know you are busy, and we will arrange our visits at times convenient to you. We will also respect the routines and responsibilities of the caregiver(s) during our visits. We want to see what the child is usually like when she/he is with you. We would just watch whatever the child typically does and ask some questions about how she/he usually spends the day. We would also ask you some questions about your own education, child care experiences, and feelings about providing child care.

Your participation in the study will provide valuable information which will help all of us learn more about young children's development. All of this information will be kept strictly confidential. We will be calling you to tell you more and to answer any questions that you may have about the study.

Sincerely,

Project Coordinator

Enc: Study Description

B5. Description of study

THE NATIONAL INSTITUTE OF CHILD HEALTH AND DEVELOPMENT

STUDY OF EARLY CHILD CARE

Children born today will be growing up in a world different from that of their parents. How will growing up in the 1990's affect children's development? To answer this most important question for America's future, the National Institute of Child Health and Human Development has funded the NICHD Study of Early Child Care.

The NICHD Study of Early Child Care is being conducted at ten different sites in the United States. The main aim of the study is to learn about the variety of people, places, and events that children experience in their early years and the many pathways that lead to healthy development. Aspects of development that will be studied include social, language, cognitive, and health outcomes.

Families become involved in the study on a voluntary basis soon after the infant's birth. Several times during the three years that the families are involved in the study, the children, their parents, and other caregivers will be observed and interviewed. Parents are asked to describe their views about childrearing, their feelings about working and parenting, and their perceptions of the child's personality and behavior. Because child care outside the family is also an extremely important setting in which children grow and change, caregivers are asked to participate as well. Summary results will be available to all study participants at the conclusion of the project in 1995.

VISITS TO CHILD CARE SETTINGS

Each child is the study is visited in his or her care setting on two different days, when he or she is 6, 15, 24, and 36 months of age.

At the first visit, a staff member observes the child for about 3-4 hours. She tries not to interfere with the usual routine in the child's room. At the end of the visit, she leaves 4 questionnaires for the child's caregiver(s) to fill out before the second visit. These questionnaires contain questions about the caregiver's education and experience. This should take no more than 20 minutes of the caregiver's time, and the staff members work around the schedule and routines of the caregiver(s).

At the second visit, the staff member again observes the child for about 3-4 hours. Then, she talks to the caregiver(s) briefly about the child's activities and about the caregiver's education and experience. Again this should takes no more than 20 minutes of the caregiver's time, and the staff member will be considerate of the caregiver routines and responsibilities.

Because we want to see what usually happens when children are in child care, we try to make our visit interfere as little as possible with the caregiver's routine.

The results of this study will not only guide policy makers, but will also be of more immediate use to parents and child care providers as they engage in the rewarding, but challenging, responsibility of rearing young children.

B6. Sample Appointment Letter for 24-Month Visits

Date

Name
Last known address

Dear :

This letter is to confirm the appointment that we made. I will be visiting with you at your home on (day of week, month, date, time).

We would like you to bring CHILD to our playroom at the University on (day of week, month, date, time). We will give you directions to the playroom and a parking permit before your visit.

Please remember to bring along the completed packet of questionnaires which we gave to you during the home visit. If you have any questions or problems with the form, we will be able to go over them at the time of the lab visit. Thank you for taking the time to give us this valuable information!

Please feel free to contact me at (608) 263-1565 or 263-1662 if you have any questions or concerns. I look forward to visiting with you.

Sincerely,

NAME
NICHD Study of Early Child Care

CHAPTER 20

OVERVIEW OF THE 24-MONTH VISITS:

HOME, LAB & CHILD CARE VISITS

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CHAPTER 20

OVERVIEW OF THE 24-MONTH VISITS:

HOME, LAB & CHILD CARE VISITS

I. OVERVIEW OF THE HOME, LAB, AND CHILD CARE VISITS

When the child is 24 months of age, data will be collected in the home, the lab, and the child care arrangement. The following is a list of the visits and the measures collected:

A. HOME VISIT

1. Arrival and overview of visit
2. Q sort observation (2 hours)
3. Q sort questions
4. Distribution of the MacArthur Language Inventory
5. Questionnaire packet explanation
    - a. My Feelings (CES-D) - Ensel
    - b. Parental Care (Maternal Separation Anxiety Scale) - Hock, Gnezda, & McBride
    - c. Parent Experiences - Marshall
    - d. Relationships With Other People (Availability of Social Support) - Marshall
    - e. Family Finances - Marshall

    For mothers employed 10+ hours per week:

    - f. Job Experiences (Job Stress) - Barnett & Marshall
    - g. My Child Care - Alison Clarke-Stewart

6. Wrap-up (Debriefing, thank you, payment, discussion of next visit)

B. LAB VISIT

1. Welcome and initial instructions (5 minutes)
2. Solitary play and clean-up (20 minutes)
3. Bayley (30 minutes)
4. Snack (10 minutes)
5. 3 Boxes (15 minutes)
6. Interview (40 minutes)
    a. Interview Section 1 (Part 1 and 2)
    b. Child Behavior Checklist
    c. Interview Section 2 (Parts 3, 4, 5, and 6)
    d. Adaptive Social Behavior Inventory
    e. Interview Section 3
        - Collecting (or distributing) the Standardized Questionnaire packet. Administering the MacArthur Language Inventory (optional for reading mothers)
        - Describing the ear infection data collection procedures
        - Administering "The Year Before My Child Was Born"
        - Debriefing and Updating Addresses
7. Growth Measures (10 minutes)
8. Wrap-up (Debriefing, thank you, discussion of the next visit) (10 minutes)

C. CHILD CARE VISITS

*First Visit

1. Introductions, getting settled (10 minutes)
2. 1st ORCE observation cycle CR (30 minutes = Behaviorals CR/14 minutes = Qualitatives) (44 minutes)
3. 2nd ORCE observation cycle (same as before) (44 minutes)
4. 3rd ORCE observation cycle (if appropriate) (44 minutes)
5. Profile observation (40 minutes)
6. Post Visit Interview (3 minutes)
7. Instructions for questionnaires
    - a. Parent Leaves (Separation/Reunion Scale) - McCartney
    - b. Parent Returns (Separation/Reunion Scale) - McCartney
    - c. Ideas About Raising Children (Parent Modernity Scale) - Schaefer & Edgerton
    - d. Taking Care of Young Children - Marshall
    - e. My Feelings (CES-D) - Ensel
    - f. Child Behavior Checklist (CBCL) - Achenbach
    - g. Adaptive Social Behavior Inventory (ASBI) - Scott
8. Ratings of the Caregiving Environment (2 minutes)
9. Wrap up (Thank you, confirm second visit time and date)

*Second Visit

1.	3rd or 4th ORCE cycle	(44 minutes)
2.	4th or 5th ORCE cycle	(44 minutes)
3.	2 Caregiver interviews	
	a. Post Visit interview	(3 minutes)
	b. Profile interview	(10 minutes)
	c. Home Inventory	(20 minutes)
	d. Background interview	(15 minutes)
4.	Ratings of the Caregiving Environment	(2 minutes)
5.	Pick up questionnaires	
6.	Wrap up (Thank you, payment)	

II. SCHEDULING THE VISITS (Summary)

A. Begin the phone calls to schedule the visits (home, lab and child care at 23 months.

B. The 3 visits must take place between 24 months, 0 days and 26 months, 0 days. Exception period is from 26 months, 0 days to 29 months, 0 days. No data can be collected on or after 29 months, 0 days.

C. The home visit needs to precede the lab visit.

D. The child care visits need to be within one month of the home visit.

III. RULES FOR OVERLAP OF STAFF BETWEEN VISITS

A. The same person should not do both the home and child care visits.

B. Who may do a 24 month home visit Q-set rating for a given family?

1. The person may have made an earlier home visit. It will be recorded whether or not the visitor has had previous contact with THIS family.
2. The person may NOT have collected data for the child care OR lab visits at 6 months, at 15 months OR at 24 months for THIS family.
3. The person may NOT have seen the Strange Situation live or on tape for THIS child.
4. The person may NOT have conducted the 23 month phone call.
5. If a second person goes on the visit, there are no restrictions on previous contacts with THIS family so long as the person is not doing a Q-set rating.

CHAPTER 21

ADMINISTRATION OF 24-MONTH CHILD CARE VISITS

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Chapter 21

ADMINISTRATION OF CHILD CARE VISITS (24 MONTHS)

I. PURPOSE OF THIS CHAPTER

This chapter provides guidelines for the child-care assessment visits to assure that these visits are conducted in a standard way across the ten sites participating in the NICHD Study of Early Child Care. In addition, it will serve as the archival description of the methods used in the child care data collection. Amendments or suggested revisions should be addressed to Kathleen McCartney, the chair of the 24-month child care sub-committee. We acknowledge the help of Deborah Phillips (primarily responsible for Profile, and interviews); Kathleen McCartney and Alison Clarke-Stewart (primarily responsible for behavioral observations and questionnaires); Jay Belsky (primarily responsible for qualitative ratings); and Robert Bradley (primarily responsible for the Child Care HOME measure.) A special note of thanks is owed to Nancy Keefe for her help with the preparation of this manual.

It is vital to the success of the Study that the interview and observational data be collected in as identical a fashion as possible across sites. In this chapter, you will find suggestions about how to interpret both interview and observation items, as well as how to administer the interview and collect the observational data. These procedures must be followed by all research assistants to ensure the comparability of the data across sites.

We have attempted to consider as many questions and contingencies as possible. However, situations that we have not anticipated will arise during the course of data collection. When you are presented with a situation that is not covered in the manual, capture it as accurately as possible (e.g., write the caregiver's exact question about an interview item), then contact Kathleen McCartney at UNH with a cc to Bonnie Knoke at the Data Center. Kathleen will confer with the relevant individuals and give you a coding decision, an interpretational decision, or whatever is needed. Each of these new decisions will be recorded in an appendix to this manual that will be distributed to all sites (with immediate BITNET messages for on-going updates).

II. RECRUITMENT PROCEDURES

The overall recruitment strategy for child-care providers is based on a set of common guidelines and procedures. However, within these, flexibility and multiple approaches will undoubtedly be necessary. These procedures are described, in detail, in Chapter 13, Administration of the Twenty-three-Month Phone Interview.

This chapter picks up the process at the point that the provider/director is contacted. In general, the common guidelines are, first, to ask the mother during the 23-month phone call for permission for us to contact the child-care provider directly, and, second, to ask the mother to contact/persuade the caregiver if our attempt to get the mother's permission to make the first call fails or if our first attempt to obtain the caregiver's consent to visit is unsuccessful.

A. Child-Care Recruitment: General Approach

You must first determine whether the target child has a primary provider and, if so, the identity of this provider. This information is contained in the 23-month telephone interview data. If there is no primary provider, there is no child care visit. If there is a primary provider, invoke the scheduling procedures for centers and homes (including care in the child's own home or another home, by a relative or non-relative), described below. This should be done as soon as possible after the 23-month telephone interview is completed.

You will then use one of two approaches to contacting the provider. The preferred approach is to contact the primary child care provider (homes) or director (centers) directly. The alternative approach is to have the mother contact the provider/director prior to your contact.

In your scheduling call, you will explain the visit, answer any questions, obtain an initial verbal consent, and schedule 2 visits. (Center directors will also be given a telephone interview at this call - see center recruitment, below.)

Sometimes mothers will give you information about their child care arrangement during the 23-month call that is later contradicted by the caregiver when you call him/her to set up an observation. In general, it is good practice to try to reach the mother and to clarify the contradictory information. So, for example, if you call the caregiver and learn that he/she stopped caring for the target child "2 weeks ago", you will need to talk with the mother about her current arrangements. In fact, you should complete a new 23-month phone call if you learn that her situation has changed. This form should not be mailed to the Data Coordinating Center until the child care visits have been completed.

Certainly, if a caregiver has not seen the Target Child for more than two weeks, you should not collect any data on this arrangement.

Similarly, if you talk to the caregiver and learn that the Target Child is not awake for at least 3 hours on a typical day, then you should confirm this information with the mother and, if it is true, then you would not collect any data on this arrangement. IN this case, the arrangement does not meet our criteria for observable child care. Find out if there is secondary arrangement that meets the criteria for observing.

You should never ask a caregiver to wake up a child!

The windows for the two 24 month child care visits are as follows:

	24 Month Visit
Schedule between	24 months, 0 days to <26 months, 0 days
Exception period	26 months, 0 days to <29 months, 0 days
No data on or after	29 months, 0 days

All data collected during the exception period must have the written approval of a principal investigator. Fill out the EXCEPTION PERIOD DATA COLLECTION APPROVAL form and have the principal investigator sign it. See Chapter 14 for more information on this form. Because of the danger of cancellations all visits should be scheduled as early in the window as possible.

Other scheduling constraints for the child care visits are:

- First child care visit should be within 1 month of the home visit, and preferably within 2 weeks
- Second child care visit should be within 2 weeks of the first visit, and preferably within 1 week
- Do not schedule any visits before the target child has been enrolled in the arrangement for at least two weeks

Thank the provider/director for being part of the study and mail out the appointment confirmation letter, the description of the study and visits, and if required at your site, the consent form. Center directors will also be sent the Director Questionnaire and the Director Background Information Questionnaire (see Center Recruitment, below). Some sites may wish to send out the description of the study and visits after the 23-month phone call and before the child care visitor contacts the provider.

If you cannot reach the provider/director by phone, send the RECRUITMENT letter and STUDY DESCRIPTION. Then follow-up with another call or ask the mother to have the provider call you.

The day before the first scheduled appointment, call the provider/director to confirm the visit.

If the provider/director refuses a visit, information about the arrangement should be obtained through a telephone interview with the director (centers) or mother (MOTHER INTERVIEW FOR CHILD CARE WE CANNOT VISIT).

CENTER-BASED CARE CONTACTING THE DIRECTOR

STEP 1 Child care coordinator (or person responsible for scheduling child care visits) contacts the center director OR mother contacts the center director.

STEP 1B IF MOTHER CONTACTS DIRECTOR, coordinator re-contacts mother for update, then contacts director.

STEP 2 Coordinator schedules 2 visits and asks the director to inform all classroom staff who provide care for target child about the study and the timing of the visit OR follows director's advice to contact the staff directly.

STEP 3 Conduct the Director Telephone Interview

STEP 4 Send (a) letter confirming the visits, (b) study description, (c) Director Questionnaire, and (d) Director Background Information Questionnaire. If required at your site, also send the consent form.

STEP 5 Call director the day before the actual observation to reconfirm the visit. Remind him/her to complete the director questionnaire.

IF THE DIRECTOR REFUSES THE VISIT, ask his/her permission to conduct the "DIRECTOR TELEPHONE INTERVIEW FOR CENTERS WE CANNOT VISIT". If he/she refuses, use the comparable mother Interview.

HOME-BASED CARE (including in-home care by fathers and other relatives) CONTACTING THE PROVIDER

STEP 1 Child care coordinator (or person responsible for scheduling child care visits) contacts the provider OR mother contacts the provider.

STEP 1B IF MOTHER CONTACTS PROVIDER, coordinator re-contacts mother for update, then contacts provider.

STEP 2 Coordinator schedules two visits with provider

STEP 3 Send (a) letter confirming the visits and (b) study description. If required at your site, also send the consent form.

STEP 4 Call provider the day before the actual observation to reconfirm the visit.

IF THE PROVIDER REFUSES THE VISIT, conduct the "Mother Telephone Interview about Child Care for Home Arrangements we Cannot Visit."

The following two sections - CENTER RECRUITMENT and HOME RECRUITMENT - elaborate these procedures for these differing types of arrangements. In some cases, it will not be clear whether an arrangement is a center or home. Consider it a home if the setting is used as a residence, even if it resembles a center in room arrangements, numbers of children, etc. This will often be considered a "Group Family Day Care Home" by licensing officials.

B. Center Recruitment

1. Contacting the Director

Contact the center director by phone as soon as possible after getting information about the child's care arrangement from the mother or after the mother's contact with the director. If your site prefers to send the literature to the director and then make the phone call, that is allowable. But be aware of the window for the child-care assessment (2 months after the child's 24-month birthday). In the phone call, briefly explain the study, summarize what is involved on the directors' and teachers' parts, answer any questions, and obtain an initial verbal consent. Also explain to the director that all of the staff who provide care for the target child need to be informed about the study and they will need to sign the consent form. Offer two approaches: the director may contact the staff or you may contact them directly. Do what the director suggests. If you cannot reach the director by phone, send the RECRUITMENT LETTER AND STUDY DESCRIPTION and follow up with another call or ask the mother to have the director call us.

If the director says "no" at this point, try to find out why. You may be able to assuage his/her concerns. Ask if you might send the materials (RECRUITMENT LETTER AND STUDY DESCRIPTION) and call him/her back. Ask if you may just ask a few questions over the phone either now or later (preferably now). Explain that it will take about 15 minutes (see below: 3. When it is not possible to do the Child Care Assessment)

In addition, in cases of refusal, if the child has a secondary arrangement in which he/she is enrolled for at least 10 hours a week, call the mother back and ask if we can repeat the recruitment process for this provider.

Talking Points for Child-care Recruitment

Following is a list of "talking points" for Child-care Recruitment. Adapt these talking points, as appropriate, for centers you have already visited.

- Explain the overall purpose of the study using the consent form as a guide. For example: children are growing up under very different circumstances today; child care has become a very important part of most children's lives; we need to understand how this affects children's development; etc. Note national significance, importance to children and families, child care providers etc.
- Describe the visit from the provider's perspective:
    - Two days of visits;
    - Three hours each;
    - Prefer mornings, if target child is typically awake then;
    - We will start by talking briefly with director, and then go immediately to the target child's classroom.
    - Most of our time will be spent observing the target child. THIS DOES NOT REQUIRE ANY CHANGES IN YOUR TYPICAL ACTIVITIES. In fact, we don't want anything unusual to happen;
    - We will also be observing the target child's classroom.
    - And, we will interview up to 2 of the child's providers (about 30 minutes each)

- All procedures will be maximally convenient for the provider (we can be flexible).
- All data are confidential (nothing is reported to any licensing agency. Our purpose is research, not evaluation). The only thing we would need to report is child abuse.
- We will be paying $40 for his/her/their participation. (In cases of multiple providers, find out how the director would like this to work, e.g., divide among providers, program gift, etc.).
- Complete TELEPHONE INTERVIEW, with the director.
- Again, stress the importance that he/she talk to his/her staff who take care of the target child. You may need to volunteer to visit in advance.

The following is a sample telephone script to be used with centers that includes the points mentioned above:

Script for Caregiver Phone Call (Center Care)

"Hi. My name is ________. I am on the staff of the NICHD Study of Early Child Care. (If you have already visited the center, say, "You may remember that we observed CHILD at your center when he/she was 15 months old" or "You may remember, we observed OTHER CHILD at your center recently.") CHILD'S NAME who attends your center has been part of our study since birth. I sent you a letter last week describing the study. Did you receive it?

IF DIRECTOR DID NOT RECEIVE THE INFORMATION, THEN DESCRIBE THE STUDY. *The study seeks to learn how different people and places affect children's development. Because child care is such an important part of many children's lives, we want to observe children in their child care setting. Children in the study are visited in their homes and child care settings when they are 6, 15, 24, and 36 months old. I would like to come to observe CHILD when he is at your center when he/she is about 24 months old.*

Let me give you an overview of what I would like to do. When CHILD is about 24 months old, I would like to visit your center for a couple of mornings. The first morning I would start by talking briefly with you (director) and going over your answers to two brief questionnaires that I will have sent you ahead of time. (It just asks a few questions about the center.) I would then go to CHILD'S room. Most of my time in the room would be spent observing CHILD. This would not require any changes in his/her room's typical activities. I would also interview (for about 30 minutes) a maximum of 2 of CHILD'S providers. Finally, I would leave some brief questionnaires for them to fill out.

Of course, all information we collect is confidential. We are not part of any licensing agency.

In appreciation for your participation in this project, we would like to provide your program with $40. It can divided among the child's providers or as a gift to the program, whichever you prefer.

May I schedule these visits?

IF YES, Do you know CHILD schedule well enough, or should I talk with someone else? I need to come at a time when CHILD will be awake for about two hours. I would like to come in the mornings if possible.
SCHEDULE VISIT IF POSSIBLE.

IF NO, *Would you like for me to send you additional information about the study?* SEE PROBLEM SOLVING SECTION.

I will be sending you some information to look over and also a letter confirming the visit dates and times.

Also, I'd like to get a little information about CHILD room before I come. START DIRECTOR TELEPHONE INTERVIEW (For notes on specific questions, see p. 62.)

Thank you for your time.

2. Scheduling the Visit

If the director says "yes", schedule a visit, using the following questions:

(1). When you are speaking to the director of a center, ask if she knows the child's schedule well enough to be able to schedule the visit; if not, ask if you should speak to the child's caregiver to get the best times. Also ask the director the questions on the DIRECTOR TELEPHONE INTERVIEW. Then, ask the appropriate individual, "*In your opinion, considering your schedule and the CHILD'S, what would be the best time for us to schedule a visit? I need to see the CHILD when he/she is most likely to be awake and not likely to be interrupted by someone coming to visit (for example, the mother coming to feed him/her). I will need to make two visits of about three hours each*".

The child is most likely to be awake and available in the morning, so if you have a choice, please schedule the visit so that it occurs predominantly during the morning hours. Of course, some children will not be in child care at all during the morning.

(2). What day of the week is best for you? Do not observe children until they have been in the center (and the same classroom) for at least 2 weeks. Aim for as close to the child's 24-month birthday as possible. It is extremely important that the child-care visit be scheduled within 2 months after the child's 24-month birthday.

Schedules should aim for the second child care visit to be within 2 weeks of the first child care visit and preferably within one week. The first child care visit should aim to be within 4 weeks of the home visit, preferably within 2 weeks. Schedule the visit at a time that the child's REGULAR caregiver(s) will be there. (Accept no substitutes!) If the regular caregiver is absent on one visit it will have to be rescheduled.

(3). Select times and dates for the two visits, and include this information in the confirmation letter to the director.

Thank the director for being a part of the study and tell him/her that:

(1) You will call back the day of the visit to confirm the appointment and to make sure the child is there;

(2) The director should receive, before your visit, a letter confirming dates and times of the visits and a description of the Study and the visits. Tell the center director that he/she can post this description for parents to see, if he/she wishes.

(3) If your site requires that a consent form be sent in advance, tell him/her that this also will be included with the letter.

(4) He/she will also receive, with the letter, two brief questionnaires (Director Questionnaire and Director Background Information Questionnaire.) that you would like him/her to fill out before the visit. Explain how to fill out the questionnaire. If the Director has been visited before, see page 61, the section on which forms to use when a child care arrangement has been visited before.

(5) Make sure that the director will communicate the information about the visit to the staff in the child's room. Offer to talk directly to the staff before the visit if he/she thinks this would be wise. Remind her that these staff will need to sign the consent form, along with the director, in order for you to collect any data.

You will then send:

(1) the confirmation letter;

(2) the description of the Study and visits;

(3) the Director's Questionnaire and Background Information Questionnaire (Long or Short); and if necessary

(4) a consent form (if required at your site).

3. When it is Not Possible to Do the Child-care Assessment.

You need to conduct a separate telephone interview to obtain crucial information about the target child's child-care arrangement. This interview will ideally occur with the center director, but may occur with the mother, if the director refuses.

The "Director (or Mother) Telephone Interview for Centers We Cannot Visit" is used if either the mother does not want us to observe in the center or the center policy does not allow us to observe. It is used instead of the regular Director Telephone Interview, the regular Director Questionnaire, and the Child Care Observation. If the director refuses to be interviewed, use the "Director (or Mother) Telephone Interview for Centers We Cannot Visit" with the mother. If the mother is the respondent and she does not know the answer to any of the questions ask her to find out and you will call back later. (You can send her a copy of the questions to help her remember what to ask.)

The form (11B) for interviewing center directors (or mothers) who will not permit an on-site center visit contains a space for filling in the center/director ID. IT IS ESSENTIAL THAT YOU ASSIGN IDS TO ALL CHILD CARE ARRANGEMENTS, WHETHER VISITED OR NOT. Please write in a caregiver ID number using the instructions for assigning all IDs.

A validity check will be performed on these interviews, by having a subset of study sites conduct the interviews with directors/mothers on whom we also collect live data.

4. Confirmation Phone Call to Director

The day of the scheduled appointment, call the director or caregiver to make sure all the principal actors are present and accounted for, and that there is not an unforseen plague or other calamity giving you a reason to postpone the visit. Make sure the child and the child's primary caregiver are present. If they are not, find out from the director/caregiver how long the child or the primary caregiver will be away and reschedule your visit. Make sure that the center director will have completed the Director's Questionnaire and Director Background Information Questionnaire before your visit. Answer any questions he/she has about the questionnaire or the visit. Make sure that the director has informed the staff in the child's room of your visit and that she or someone else in authority will be there to sign the consent form for the director when you come. If he/she will not be there, make sure that it will be OK for someone else on the staff to sign for her. Ask her to have the classroom caregiver call you directly if she has any questions about your visit, and then be available to take the call.

5. Obtaining Consent

Consent should be obtained from the director and from individual caregivers as well, after you arrive at the site and before you begin your observations.

In some cases, CGs may be less than 18 years of age. It is very important that you include these caregivers in the child care assessments. Sometimes, the child's only caregiver will be under 18 years of age. Other times, the child will have multiple caregivers, one of whom is under 18 years of age.

This poses a question for the consent forms. You should clarify procedures with your human subjects committee. In some cases, it may be necessary to obtain the consent of the caregiver's parent. Perhaps this consent can be obtained over the telephone. Perhaps it is required only if the under age caregiver is not being supervised by an older caregiver. You will need to get answers to these questions for your site. But, we repeat, we need data on these caregivers -- they are a particularly interesting group.

6. Center Payment

Each participating center will be paid $40 at the end of the second visit. (Some sites may wish to assure that all questionnaires are completed prior to payment.) For centers you will need to ask the director how he/she wishes to handle the payment. Some may wish to divide the payment equally among all participants; others may wish to purchase a gift for the center. Please be as flexible as you can.

C. Home Recruitment

1. Contacting the Provider

Contact the primary child-care provider by phone as soon as possible after getting information about the child's care arrangement from the mother or after the mother's contact with the provider. If your site prefers to send the literature to the child-care provider and then make the phone call, that is allowable. But be aware of the window for the child care assessment (2 months after the child's 24-month birthday.) In the phone call, briefly explain the study, summarize what is involved on the providers' part, answer any questions, and obtain an initial verbal consent. If you cannot reach the provider by phone, send the RECRUITMENT LETTER AND STUDY DESCRIPTION and follow up with another call or ask the mother to have the provider call us.

If the provider says "no" at this point, try to find out why. You may be able to assuage his/her concerns. Ask if you might send the materials (RECRUITMENT LETTER AND STUDY DESCRIPTION) and call him/her back. If the provider is adamant, we cannot force ourselves upon him/her. We will then have to use the mother as our sole informant about the child's care arrangement (see below).

In addition, in cases of refusal, if the child has a secondary arrangement in which he/she is enrolled for at least 10 hours a week, call the mother back and ask if we can repeat the recruitment process for this provider.

Talking Points for Child-care Recruitment

Following is a list of "talking points" for Child-care Recruitment. Adapt these talking points, as appropriate, for homes you have already visited.

- Explain the overall purpose of the study using the consent form as a guide. For example: children are growing up under very different circumstances today; child care has become a very important part of most children's lives; we need to understand how this affects children's development; etc. Note national significance, importance to children, families, and providers.
- Describe the visit from the provider's perspective:
  - Two days of visits;
  - About 3 hours each;
  - Prefer mornings, if target child is typically awake then;
  - Most of the time will be spent observing the target child. THIS DOES NOT REQUIRE ANY CHANGES IN YOUR TYPICAL ACTIVITIES. In fact, we don't want anything unusual to happen;

  - ** We will be observing the environment in which the child spends his/her time.
  - ** And, we will conduct an interview with you (about 30 minutes)
- * All procedures will be maximally convenient for the provider (we can be flexible).
- * All data are confidential (Nothing is reported to any licensing agency. Our purpose is research, not evaluation). The only thing we would need to report is child abuse.
- * We will be paying $40 for his/her/their participation. (In cases of multiple providers, find out how they would like this to work, e.g., divide among providers, program gift, etc.).

The following is a sample telephone script, for family day care, that includes the points mentioned above.

Script for Caregiver Phone Call (Family Day Care)

"Hi. My name is ________. I am on the staff of the NICHD Study of Early Child Care. (If you have already visited home, say, "You may remember that we observed CHILD at your home when he/she was 15 months old" or "You may remember, we observed OTHER CHILD at your home recently.") CHILD who you care for has been part of our study since birth. IF SENT INFORMATION AHEAD OF TIME, *I sent you a letter last week describing the study. Did you receive it?*

IF THE CAREGIVER DID NOT RECEIVE THE INFORMATION, THEN DESCRIBE THE STUDY *The study seeks to learn how different people and places affect children's development. Because child care is such an important part of many children's lives, we want to observe children in their child care setting. Children in the study are visited in their homes and child care settings when they are 6, 15, 24, and 36 months old. I would like to come to observe* CHILD *when he/she is in your care when he/she is about 24 months old.*

Let me give you an overview of what I would like to do. When CHILD *is about 24 months old, I would like to visit you for a couple of mornings. The first morning I would spend most of my time watching what the child does when he/she is in your care. This would not require any changes in your typical activities. The second day I would also talk to you (and your helper) at the end of my visit for about 30-45 minutes about your background experience and about how you handle child care. At the end of the first visit I would leave you (both) some brief questionnaires to be completed when you are able. I would pick them up at the second visit.*

Of course, everything is confidential. We are not part of any licensing agency.

In appreciation for your participation in this project, we would like to provide you (and your helper) with $40. (That is, $20 for each of you.)

Is it okay if I come?

IF YES, *Great! I need to come at a time when CHILD will be awake for at least two hours. I would prefer to come in the mornings if possible.*
SCHEDULE VISIT IF POSSIBLE.

IF NO, *Would you like for me to send you additional information about the study?* SEE PROBLEM SOLVING SECTION.

I will be sending you a consent form for you to look over and also a letter confirming the visit dates and times.

Thank you for your time.

If the provider says "yes", schedule a visit, using the following questions:

(1). "*In your opinion, considering your schedule and CHILD's, what would be the best* *time* *for us to schedule a visit? I need to see CHILD when he/she is most likely to be* *awake for at least two hours and not likely to be interrupted by someone coming to visit (for example, the mother coming to feed him/her). I will need to make two visits of about 3 hours each".*

The child is most likely to be awake and available in the morning, so if you have a choice, please schedule the visit so that it occurs predominantly during the morning hours. Of course, some children will not be in child care at all during the morning.

(2). What day of the week is best for you? Do not observe children until they have been in an arrangement for at least 2 weeks. Aim for as close to the child's 24-month birthday as possible. It is extremely important that the child-care visit be scheduled within the 2 month window after the 24-month birthday. Between 26 months 0 days and <29 months 0 days, 24 month visits may be conducted, but flagged as exceptions. On or after 29 months 0 days a 24 month child care visit is not conducted.

Schedules should aim for the second child care visit to be within 2 weeks of the first child care visit and preferably within one week. The first child care visit should aim to be within 4 weeks of the home visit, preferably within 2 weeks. Schedule the visit at a time that the child's REGULAR caregivers will be there (no substitutes). If regular caregiver is absent for one visit, it will have to be rescheduled.

(3). Select times and dates for the two visits, and include this information in the confirmation letter to the provider.

Thank the provider for being a part of the study and tell him/her that:

(1) You will call back the day of the observation appointment to confirm the appointment and make sure CHILD is there;

(2) Before your visit the provider should be sent a letter confirming the visits and a description of the Study and the visits. Tell the provider that he/she can post this description for parents to see, if he/she wishes;

(3) If your site requires that a consent form be sent in advance, tell him/her that this will also be included with the letter.

You will then send:

(1) the confirmation letter;
(2) the description of the Study and visits;
(3) a consent form (if required at your site).

2. When it is Not Possible to Do the Child-care Assessment

You need to conduct a separate telephone interview to obtain crucial information about the target child's child-care arrangement. If the mother will not allow us to visit the provider in a home-care arrangement or if the home caregiver refuses to be visited, the "Telephone Interview about Child Care for Home Arrangements We Cannot Visit" (Form 11C) is completed. Conduct this interview with the provider, if possible. If not, conduct the interview with the mother. If the mother is the respondent and she does not know the answer to any of the questions, ask her to find out. You can send her the questions to help her remember what to ask.

The form (11B) for interviewing center directors (or mothers) who will not permit an on-site center visit contains a space for filling in the center/director ID. IT IS ESSENTIAL THAT YOU ASSIGN IDS TO ALL CHILD CARE ARRANGEMENTS, WHETHER VISITED OR NOT. Please write in a caregiver ID number using the instructions for assigning all IDs.

A validity check will be performed on these interviews, by having a subset of study sites conduct the interviews with mothers on whom we also collect live data.

3. Confirmation Phone Call to Provider

The day of the scheduled appointment, call the provider and confirm that the date for the observation is still okay and that the child is there. Answer any questions he/she has about the visit.

4. Obtaining Consent

Consent will be obtained from the provider and from any additional helpers/providers who are observed, after you arrive at the site and before you begin your observations.

In some cases, CGs may be less than 18 years of age. It is very important that you include these caregivers in the child care assessments. Sometimes, the child's only caregiver will be under 18 years of age. Other times, the child will have multiple caregivers, one of whom is under 18 years of age.

This poses a question for the consent forms. You should clarify procedures with your human subjects committee. In some cases, it may be necessary to obtain the consent of the caregiver's parent. Perhaps this consent can be obtained over the telephone. Perhaps it is required only if the under age caregiver is not being supervised by an older caregiver. You will need to get answers to these questions for your site. But, we repeat, we need data on these caregivers -- they are a particularly interesting group.

5. Provider Payment

The provider will be paid $40 at the end of the second visit. (Some sites may wish to assure that all questionnaires are completed prior to payment.) For family day-care homes with more than one provider who has been involved, you will need to ask the owner how he/she wishes to handle the payment. Some owner may wish to divide the payment equally among all participants; others may wish to purchase a gift for the home. Please be as flexible as you can.

D. Problem Solving

1. Trouble Making Contact With Caregiver/Director.

The caregiver or the director of the center is not available when the project staff person calls. A person other than the caregiver (home daycare) or director (center daycare) answers the phone or a machine answers the phone:

"*Hello. This is (your name) from the Study of Early Child Care. (Name of child) is in (name of provider's) care. (Name of child) and his/her mother are part of a study on early child experiences and development. (Name of mother) has agreed to participate in the study and has contacted caregiver/provider (or you) about the possibility of observing (name of child) while he/she is in (name of caregiver/director/your) care. Could (he/she) (you) please call me back today or tomorrow at the following number:* "

If speaking to a person add:

"*I am sure he/she is very busy so I hope it's okay for me to call (her/him) back if I don't hear from (her/him). Is there a* *good time when I might reach (her/him) today or tomorrow? Thank you. Bye."*

Make the second phone call at the time suggested, or some time during the following day. If the caregiver/provider is still not available, leave another message asking that he/she get back to you within the day.

If the phone call is not returned after the second try (second day) and no reason is given for the caregiver/provider's unavailability, then follow up with a third call the following day (third day) to leave a third message.

If by the morning of the fourth day (at the latest), the caregiver/provider has not returned your call, and the mother has made the original contact, call the mother, asking her to approach the caregiver/provider again with the following message (we are not asking the mother to read this to the caregiver/provider, but to try to include the following points when speaking again with the caregiver/provider):

"As you may know (name of child) and I are involved in the Study of Early Child Care. The staff for the project would like to speak with you to discuss their study and your possible participation. They are having difficulty reaching you. I know you are very busy but they feel your input is very important to the study. Would you mind speaking with her/him within the next couple of days about the study and the possibility of a visit.

Is there a good time for them to reach you to discuss the study and a possible visit?"

Alternatively, you could at this point send the RECRUITMENT letter and a note suggesting that the director call you at her convenience.

If the caregiver is still unresponsive, the project staff person could suggest that the mother ask the caregiver/provider if he/she would like to be introduced to the project visitor before he/she agrees to participate.

2. During Contact With the Caregiver/Director, the Provider Says "no" or is Ambivalent About Participation

Try to find out why. If the provider is adamant about refusing to discuss participation, we have a missing child-care observation. If the caregiver is willing to discuss refusal or is ambivalent about participation, use the following troubleshooting suggestions to encourage participation:

Discussing the study and its importance. Summarize what is in the Study Description, emphasizing its importance to children, its national significance, and the critical importance of caregiver provider participation in the study. If he/she has received the description, ask if he/she had a chance to read the description and if there are any questions about the study or his/her participation? Mention that the caregiver/provider/center will receive a payment of $40 at the end of the second visit in appreciation for their time and input.

Provider/Director is concerned the visit would be too disruptive to normal routines. Explain that:

- The date and time of the visits are arranged for the convenience of the caregiver/director;
- Our project staff person will be as non-intrusive as possible;
- Our primary purpose is to observe the child in normal circumstances. We do not want any special arrangements made for the visit (changes in schedule, etc.);
- We understand your primary responsibilities are to the children;
- Although we do need to speak with you about your views and past experience, this brief interview can be at your convenience and you can request that we leave at any time, if you feel circumstances warrant it.

The caregiver/director is concerned about the privacy of the staff and other children and parents. Explain that:

- All observations and staff comments are kept confidential and are shared only with project staff (with the exception of child abuse);

- Any information from the observations or interviews will not be shared with the parent (of course, overall study results will be made available to any interested caregiver/provider.);
- No information will be gathered on other children in their care;
- Any caregiver who is observed at a center is asked for consent prior to the observation.

Caregiver/Director wants to think about it first or discuss it further with the staff before giving consent or scheduling a visit. Ask for a specific time to call back to discuss their participation. If necessary, mention that we do have a time constraint in that we need to see the child as close as possible to his/her 24th month birthday. If all else fails, go back to the mother again and see if she can persuade the caregiver.

The caregiver/director seems concerned that you may report your findings to licensing officials. This is particularly pertinent to family daycare providers, some of whom are unlicensed and operating illegally. If you sense this is the source of a provider's hesitation, be explicit about the fact that you will not report any data or anything else that you hear or observe to licensing officials. All data are confidential. (The only reporting requirement with which you must comply concerns suspected child abuse or neglect.)

3. The Provider Takes Steps That Create an Atypical Day.

Providers may try to schedule your visits when other children are asleep, when some children are absent, or after a "problem child" has gone home. This may be a real problem in smaller, informal arrangements. If you get a sense that this is happening when you schedule or confirm the visits on the phone, you should reiterate the importance of seeing a typical day and address his/her concerns about being "tested" or about the disruptiveness of the visit.

More often, you will sense that the visit is atypical when you arrive to conduct your observation. There is little you can do at this point, unless you are willing to reschedule the visit (with no guarantee that the rescheduled visit will be more typical). In cases where the children are asleep at non-nap times and you sense that this has been done to accommodate your visit, try to wait until they wake up. There is a place on the Post Visit Interview and Ratings of the Caregiving Environment form to indicate whether you felt you have captured a typical day. Indicate "no" in these cases.

4. Information About Care From the Caregiver Contradicts Information From Mother.

If the information from the caregiver contradicts the information from the mother, call the mother back to clarify. If necessary complete a new 23-month phone call (if you learn that the child care situation has changed), and send a note to the Data Center telling them to ignore the earlier 23-month phone call data if it was sent in already. Ideally, the 23-month phone call should not be sent to the Data Center until after the child care visits are conducted.

III. ASSESSMENT PROCEDURES

A. General Procedures

This section covers general considerations for the child-care visits, including the determination of when the visit should take place, the "order" in which the data are collected, the determination of which caregiver(s) to observe in the case of multiple caregivers, and procedures in the case of a single arrangement being used by more than one Study child.

1. Number of Visits

All data collection should occur within two visits, unless there are circumstances that prevent the collection of the minimum required data in two visits and a third visit is necessary. You should do everything in your power to keep to 2 child care visits per arrangement. Do not return a third day, for example, to complete your fourth ORCE cycle unless this is absolutely unavoidable. Be careful not to overstay your welcome. Do not pressure caregivers to complete their interviews or to let you stay longer when it is obvious that your presence is not wanted.

2. Timing of Visits

The windows for the 24 month visits are as follows:

	24 Month Visit
Schedule between	24 months, 0 days to <26 months, 0 days
Exception period	26 months, 0 days to <29 months, 0 days
No data on or after	29 months, 0 days

All data collected during the exception period must have the written approval of a principal investigator. Because of the danger of cancellations all visits should be scheduled as early in the window as possible.

Other scheduling constraints for the child care visits are:

- First child care visit should be within 4 weeks of the home visit, and preferably within 2 weeks
- Second child care visit should be within 2 weeks of the first visit, and preferably within 1 week

- Do not schedule any visits before the target child has been enrolled in the arrangement for at least two weeks
- If the child care visits cannot be scheduled within the 2 and 4 week window, then exceptions must be noted.

The scheduling of the visits should be worked out with the child care provider when the appointment is made. You want times when the child is as alert as possible, and preferably in the morning.

3. Confirming the Visit

Call to the director/provider on the day of the visit to confirm the appointment and to be sure that the child is present.

4. When Child is Absent

If you arrive and you discover the child will be absent that day, reschedule the visit, trying, insofar as possible, to stay in the window. DO NOT COLLECT ANY DATA if the target child is not there. As described below, the child caregiver observations must be spread across 2 days; thus, if you collect data (e.g. caregiver interviews) on a day when the child is sick, this would put you in the position of visiting on 3 days, which should be avoided.

5. Number of Observers

Only one research assistant (RA) will visit each child-care facility, unless a second individual must accompany the RA for safety reasons or for a "live" reliability check. The observer can not be the person who was/will be the child's home visit at 6 or 15 months. Child-care and home visits must be independent. We strongly recommend that the same RA conduct both visits for a given child-care arrangement. When the 15 & 24 month CC arrangement is the same, we recommend that the same RA who collected the 15-month CC data also collect the 24-month CC data.

6. What to Bring

You should bring with you to the child-care visit the following:

* Two additional copies of the consent form -- one to leave and one to bring back signed;
* A copy of the parents' signed consent form in case the provider wants to see this;
* Multiple copies of all data forms. Remember to take: (1) extra copies of the questionnaires to the second visit in case caregivers have lost the ones you gave them at the first visit or in case the caregiver(s) you gave them to at the 1st visit are absent on your 2nd visit; and (2) another set of consent forms in case there are new caregivers;

- For centers only: The Director's Telephone Interview (filled out);
- Clipboard, "observe-record" tape or timer (use the 6 month tape); several #2 pencils;
- Stamped return envelope for caregiver to use in sending back any questionnaires not completed by the second visit; and
- Child care ID Worksheet.

7. Arriving at the Center/Home and Getting Started

In a center, find your way to the Director's office. Chat with him/her about your visit. Get the Director's Questionnaire or the Short Form of Director's Questionnaire and the Director's Background Information Questionnaire (as appropriate) both of which he/she should have completed. If he/she has not, suggest that perhaps she could fill them out before you leave or go over them with him/her on the spot. If he/she has questions about the questionnaires, answer them. Check that the questionnaires are complete. Ask him/her to describe all of the caregivers who are likely to be observed interacting with the target child and record this information on the Child Care ID Worksheet. Be sure to ask about each one's relationship to the child and whether he/she is specifically assigned to the child. Ask the Director to take you or show you to the room where you will be observing the target child. When you meet the caregivers, make sure you have completed permission forms for each caregiver who will be in the room with the child.

8. Whom to Observe, Interview, and Ask to Complete Questionnaires

In many cases, the child will have only one caregiver. However, in some large family day care homes (group homes) and in centers, the child may be cared for by more than one caregiver. In these cases, you need to determine whom to observe.

Observations will be done noting which caregivers and other adults were in the room and which caregivers and adults interacted with the child during each observation interval. All the caregivers with whom the child interacts, including non-staff adults and caregivers under 18 years of age, will be observed during the Behavior Scales observations. Because the focus is on the child's total caregiving experience, we will note which caregiver interacted during an observation period, so we can link up the behavior of individual caregivers with their individual interview data. Also see section III.G.4.a and b. ADULT AVAILABLE and ADULT INTERACTING.

When determining who to rate on the Qualitative Scales remember that the Qualitative Scales serve to document the quality of the child's caregiving experience. The general rule for determining who to rate is as follows: the Qualitative Scales are coded for caregivers who are involved with the target child for at least two of the four 10-minute segments in a 44 minute observation. If one caregiver is exclusively involved with the child, additional caregivers will not be coded on the Qualitatives, even if they are present throughout the observation. If no caregiver is ever involved, then all caregivers present (up to a maximum of 3) will be considered responsible and all will be coded. There will still be some judgement on what constitutes "involved", but it will clearly require some indication that the caregiver is supervising, directing, or responding to the child during a 10-minute segment.

When the child is involved with a "non-caregiver" during a majority of the observation time, then the Qualitative Scales are to be rated for that adult, for that observation period (as well as any caregivers that fit the above criteria). There will not be any other data collection done on these non-caregivers and they will not be assigned ID numbers. By the same reasoning, if the head teacher does not meet the "2 segments involved" or "no one involved" criteria, then the head teacher would NOT be rated on the Qualitatives for that observation period.

Up to a maximum of two of these same caregivers will be interviewed. All caregivers who are interviewed should be asked to fill out questionnaires as well. The two caregivers who are interviewed should be the following:

First, the caregiver who interacted with target child most during the two sets of observations conducted on Day 1. It is important to identify the caregiver who interacted the most with the target child, who may or may not be the caregiver who was in the preschool room the most. In centers that assign specific caregivers to specific children, you might expect that it will be this caregiver, but again, it may not necessarily be this caregiver.

Second, the "lead" teacher in the class, if he/she interacted with the target child at all during the observation.

Third, if there is no "lead" teacher, the caregiver who interacted with the child second most during the observations.

Some family day care providers will have "helpers". These are often family members who do not work full-time in the home, and many will not consider themselves to be caregivers. For our purposes, what is important is whether they provide care to the target child 10 or more hours per week, on a typical week. In this case, they are caregivers to us. They need an ID number. The primary caregiver should get a REL code of 4 (since this really is a hierarchical arrangement -- it is clear who is in charge and who is primarily responsible), and the "helper" should get a REL code of 5.

These "helpers" who meet our 10 hour a week criteria should also get the questionnaires and interviews if at all possible. And, their IDs should be indicated on the ORCE when they are observed.

Sometimes these "helpers" may be young. One site had a 16 year old helper in a family day care home. Again, as long as the 16-year old is there 10 hours or more per week, he/she gets an ID number and is treated as a regular caregiver.

If the same (two) caregivers with whom you left the questionnaires at visit 1 are not there to be interviewed at visit 2 (a situation you should try to avoid), give the second day's caregivers the questionnaires as well as interviewing them.

Sometimes a caregiver will be under 18-years of age. It is important that you include these caregivers too. This poses a problem for the consent forms. You should clarify procedures with your human subjects committee. (It may be necessary to get the minor caregiver's parents' consent - perhaps over the phone).

Ask one caregiver (preferably the caregiver who interacted the most with the TC) the Post Visit Interview Questions, and put this ID on the cover of this form (Form 11W). For the End of Visit Scales, rate up to three caregivers. Choose the 3 caregivers who interacted with the TC the most over the course of the entire visit. Put these Caregiver IDs in the white space on page 3 of the Post Visit Interview Booklet (Form 11W).

9. When Dad is the Care Provider (and Other Family Exceptions)

When the father is the care provider, the visit follows the same procedure as other home care visits, except that: (1) you use the Caregiver Interview home version for fathers; (2) you DO NOT give any father the "Taking Care of Young Children" Questionnaire or the "Parent-child Behaviors when Parent Leaves/Returns"; (3) you do not complete the items on the profile that are not applicable for care arrangements with only the target child (and sibs); (4) You do not give HHS fathers the "Ideas About Raising Children" questionnaire.

When care is provided by a sitter in the child's own home, follow the same procedure as for daycare homes. This arrangement can occur when the mother is a provider or when a babysitter comes to the child's home. When the target child alone or the target child and his/her sibs are the only children in a daycare home, follow the instruction on the Profile to drop the Individualizing section.

When care is provided in the child's own home by the mother and the mother is a child care provider, providing care for other, non-resident children at least 20+ hours a week, use the HOME INTERVIEW FOR MOTHERS WHO ARE CHILD CARE PROVIDERS; do not give the questionnaires ("Taking Care of Young Children," pick up and drop off, and "Ideas about Raising Children"); do administer the HOME.

10. Assigning Child Care ID's.

Each child-care provider observed and the center director should be assigned an identification number. It is essential that you assign IDs to all CC arrangements, whether visited or not. This ID consists of 7 digits and is tied to both the research site and the relationship (REL) code. By the 24 months observation, many programs and providers will have already been observed previously at 6 and/or 15 months. Before the visit, child care observers should check the master list to determine if any arrangement ID has already been assigned. This is a good time to check the accuracy of the ID number used at a previous assessment point. Check to see that each digit is correct. See the 49 for what to do if a caregiver already has an ID number from a previous visit. The first digit of each Provider and Director ID is the Site Code. The second digit is the Relationship Code. This code identifies the person responding to the interview/questionnaire or who was observed, and refers to the relationship of the respondent to the study child. Specifically REL should be coded as follows:

0 - Mother (in cases where the mother is a child-care provider and also takes care of the target -- her own -- child).

1 - Father (the father is the child-care provider)

2 - Grandparent (the grandparent is the child-care provider)

3 - Other Relative (another relative, including sibling, is the child-care provider)

4 - Primary Child-Care Provider (a provider with supervisory responsibility for the target child's classroom; sometimes called a head or lead teacher. Use this code, as well, for the owners of large family day-care homes, sometimes called group homes, in which more than one caregiver is employed or when the care provider's husband, mother, sister or anyone else regularly provides care for target child more than 10 hours per week. All of these other providers are assigned a REL code of 5.)

5 - Support Child-Care Provider (a provider who also takes care of the target child but who is not the teacher-in-charge for the target child's classroom, sometimes called an assistant teacher or aide, or who is not the main child care provider in a home, sometimes called a helper.)

6 - Child-Care Provider (no hierarchical designation; use in instances where all classroom teachers are of equal status, e.g., all "teachers" or all "assistant teachers"; this is also to be used in all instances where there is only one provider, e.g., in a small family day care home or in-home arrangement, given that this provider is not the mother or another relative.

7 - Director (only in centers)

As you can see, if the child-care provider is related to the child, use the relative code. If the child-care provider is not related to the child, use codes 4, 5, 6, or 7. If the child has more than one provider who fits a single relationship code (e.g., two assistant teachers), they both get assigned the same REL code. What makes the ID unique is the last four digits, as described on page 47.

The third digit, the Assignment Code, indicates whether the provider is specifically assigned to the Target Child. Ask the provider/caregiver if he/she is specifically assigned to the TC. Then assign the codes as follows:

1 = The provider is specifically assigned to the target child. For example, if the mother leaves the child to be cared for by the great grandmother, but the great uncle is always home and actively cares for the child as well, the great grandmother would be giver an assignment code of 1.

2 = The provider is not specifically assigned to the target child. For example, in the situation mentioned above the great uncle would be given an assignment code of 2.

3 = Only one provider (use in arrangement, such as father care or family day care home with no other available providers). Don't take the director's word about assignment, ask the provider.

The remaining digits in the Child-Care Provider ID (4 through 7) are the unique code for each provider, starting with

0001 and ending with 9999. Thus, the first assistant teacher who is observed/interviewed at the University of Virginia site would be assigned ID 6520001. The second assistant teacher, if applicable, would be assigned 6520002. This unique ID will be assigned after the second child care visit by the site coordinator in consultation with the child care data collector. Make sure that this final ID is written on ALL FORMS in the designated spaces.

The Director ID will serve as the Child Care ID number for center-based arrangements and the caregiver ID number will serve as the Child Care ID number for all other arrangements. In the case of large family day-care homes with more than one provider, the ID of the lead child-care provider will serve as the Child Care ID. If a family or group home is co-owned and there is not a clear primary provider, randomly assign one of the providers IDs as the arrangement ID. In cases where the same provider and/or center is visited at least twice because 2 study children use the same arrangement, or because a child was in the same care arrangement at 6 and/or 15 months, use the same ID for both observations. This is our only way of knowing that it is the same center/provider. The Site Coordinator will keep a confidential list that matches names and ID's (see Appendix: Final Care Provider ID's.)

If the center remains the same over 2 assessment points, but the director changes, complete the Director change Form. If a provider has moved from one program to another, then that provider should keep the same final 4 digits of the caregiver ID number.

During the visit, the provider IDs will be temporary (see below) and then finalized by the site coordinator or her designate after both visits to a given arrangement are completed. This will occur for visits to center-based and large family day care (often called "group homes") arrangements, in which multiple caregivers are observed, interviewed, and asked to complete questionnaires. Recall that, although a maximum of two caregivers are interviewed and asked to complete questionnaires, more than two caregivers may be observed, given the child-focus of this observation.

The "on-site" temporary ID's will be assigned using an ID worksheet (see below and Appendix), and then finalized by the site coordinator (or counterpart) after the second visit to the arrangement. BRING THE ID WORKSHEET TO THE CHILD CARE VISIT. Prior to assigning the final ID's, the site coordinator (or counterpart) should check the master list of provider names to determine if the provider or the arrangement has already been assigned a permanent ID. If the provider had been assigned an ID on an earlier visit (at 6 or 15 months or with another child) then the following procedure should be used:

1. The last 4 numbers of the ID always stay the same for a provider. This is the provider's unique ID.

2. The first number of the ID is the site code and will never change.

3. The second and third digits will change if the caregiver's position has changed.

Keeping track of caregivers' final Ids as caregivers and children change programs is a formidable task. Sites may use either of two methods. Sites may maintain a file on each caregiver seen. Files should be labeled and alphabetized by caregiver name. The file should include the caregiver's name, unique ID # (the last 4 digits), place of care, address and phone number of place of care, any other information necessary for conducting the caregiver interview if another visit will take place. The file should be updated if the caregiver switches her place of care. Also, in the file should be a list of all study children who are in the caregiver's care. This list can be added to as subjects are added. Paired with each subject's ID # should

SUMMARY

ASSIGNING CHILD CARE IDS

The identification number consists of 7 numbers and is tied to both the research site and the relationship (REL) code.

SITE CODE	(First Digit)
REL CODE	(Second Digit)

0 - Mother

1 - Father

2 - Grandparent

3 - Other relative

4 - Primary child-care provider

5 - Support child-care provider

6 - Child-care provider

7 - Director (only in centers)

ASSIGNMENT CODE (Third Digit)

1 - Specifically assigned to target child

2 - Not specifically assigned to target child

3 - Only one caregiver

UNIQUE CAREGIVER ID (4-7th Digits)

0001 - 9999

be the complete caregiver (7 digit) ID used for that subject's visit.

A second approach is to use a master list of caregivers that includes this same information.

11. Using the Child Care ID Worksheet

Assigning child care provider IDs and keeping them straight across observations will pose a major challenge in child care centers, where the target child is likely to have multiple caretakers. The CHILDCARE ID WORKSHEET (see appendix of Chapter 21) is designed to facilitate this process and assure our ability to cross-walk from the observational data to the questionnaire and interview data.

After final IDs are assigned, these are written on the child care data sent to the Data Center.

As suggested in the previous section, it is CRUCIAL that the RAs assign temporary caregiver ID numbers when they visit the center, given the high turnover rates among staff. Immediately prior to starting the observation, find out who is likely to be in the classroom (ask the lead teacher or director) and interacting with the target child. Assign each of these individuals a temporary ID number using the ID worksheet (see appendix). Of course, you may be told that only one caregiver will be seen, only to find that a second caregiver enters the classroom and interacts with the infant. Assign this individual a temporary ID for "caregiver 2" and when your observation is completed, check on this caregiver's relationship to the infant and fill this information in on the worksheet.

For each observation cycle, match your temporary ID to the actual caregivers that you observe. For example, if you observed 4 different caregivers during cycle one (1=A (Sally), 2=B (Jenny), 3=C (Feehah), and 4=D (Don)), then you observed 3 of them during cycle two (say A, B, & D) PLUS one new caregiver, you would record the following for cycle two: 1=A, 2=B, 3=E, 4=D. This will allow us to match caregiver 1 to caregiver 1, caregiver 2 to caregiver 2, and caregiver 3 to caregiver 3 across these 2 cycles. We will also know that caregiver 3 in cycle one is not the same person as caregiver 3 in cycle two. Use the space for "Description" to record permanent cues to help you keep the caregivers straight, e.g. hair, size, first name, etc. Clothes are not good cues since they will likely change from visit 1 to visit 2.

After observing for the behavioral scales, you will record data for the qualitative ratings for no more than 3 caregivers. This is described in the section on the qualitative rating procedures. For the purposes of the worksheet, indicate, for each caregiver (1 through 8) whether you consider him/her in the qualitative ratings, and which caregivers (1, 2, 3...8) number he/she was given on the qualitative ratings.

The data sheet for the qualitative ratings indicates 8 caregivers, to make it easier to match from the behavior scales to the qualitatives. NOTE that you will only rate 3 of the 8. It may be caregivers 1, 2 and 3 (persons A, B, and C) or 1, 3 and 4 (persons A, C, and D), or any other combination.

At the end of each day, you will complete the End-of-visit ratings for up to 3 caregivers. Ask one caregiver (preferably the caregiver who interacted the most with the TC) the Post Visit Interview Questions and put this ID on the cover of this form (Form 11W). For the End of Visit Scales, rate up to three caregivers. Choose the 3 caregivers who interacted with the TC the most over the course of the entire visit. Put these caregivers IDs in the white space on page 3 of the Post Visit Interview Booklet (Form 11W). Indicate on the worksheet using Cg1, 2, 3....8, which caregivers you rated, and which day it is (1 or 2). For example, caregiver 1 for the end-of-visit ratings, may be caregiver 1 (=A on chart below) from the behavioral scales, or it may be another caregiver. We need to match up these data, and so need you to match actual individuals on this worksheet.

We need to know which caregivers completed the questionnaires and the interviews. Remember that all caregivers who do the interviews also complete the questionnaires (max of 2). Put their temporary ID on the questionnaires themselves and then replace this with the final ID once you are back in your lab. Also, indicate on the worksheet which caregivers were given the questionnaires.

Finally, before you leave the center on the last day, make sure that you have assigned a REL and ASSIGN code to each caregiver. This may require speaking to the caregiver, e.g. "Are you specifically assigned to the target child?" Without this information, your site coordinator cannot assign a final ID.

Here is an example of a completed CHILDCARE ID WORKSHEET, using 2 observational cycles:

Observation Cycle #1

Behaviorals	TempID	FinalID	Desc	REL	ASSIGN	QUALS?	END-OF-VISIT?	INT/QUES?
Caregiver 1	A		short, red hair	4	2	Cg1	Cg1-Day1	yes
Caregiver 2	B		Curly black hair	5	1	Cg2	Cg2-Day1	yes
Caregiver 3	C		male, blond hair	5	2	Cg3		
Caregiver 4	D		long, red hair	5	2		Cg3-Day1	
Caregiver 5								
Caregiver 6								
Caregiver 7								
Caregiver 8								

Observational Cycle #2

Behaviorals	TempID	FinalID	Desc	REL	ASSIGN	QUALS?	END-OF-VISIT?	INT/QUES?
Caregiver 1	A		short,red hair	4	2	Cg1		
Caregiver 2	B		Curly black hair	5	1	Cg2		
Caregiver 3	E		Dark black glasses	5	2			
Caregiver 4	D		long, red hair	5	2	Cg3		
Caregiver 5								
Caregiver 6								
Caregiver 7								
Caregiver 8								

We now know that the qualitative ratings for cycle 1 considered caregivers A, B, and C and that the qualitative ratings for cycle 2 considered caregivers A, B, and D. We know that at the end of Day 1, the global ratings were completed for caregivers A, B, and D (in that order). And we know that caregivers A and B were given the questionnaires to complete and the actual questionnaires should be marked with "A" and "B" before they were given to these two individuals.

After all the data are collected, the Site Coordinator or her designate will take this information, assign final IDs, and use the final IDs to complete all of the SCANTRON face sheets for the ORCE, interviews, and questionnaires. Also, put the final IDs and names on the CONFIDENTIAL WORKSHEET (see appendix of Section 21) for assigning final IDs. DO NOT send the CONFIDENTIAL WORKSHEET used in assigning final IDs to the Data Center.

12. When to Use Center vs. Home Instruments

If an arrangement uses space that doubles as a residential home, then use the home assessment instruments and procedures. This will apply to most so-called group family day care homes, which often employ more than one caregiver and enroll 6-12 children, but operate in residential settings.

13. Overview of the Two-day Visits

At the first visit the emphasis will be on observation. Caregivers will not be interviewed at the first visit, because having information about the caregiver's background, training, etc. might bias observation of her behavior. Caregivers will be interviewed on Day 2 only, after all the required observations have been completed. You will need to be somewhat flexible, given special circumstances that will undoubtedly arise. You may suggest that the target child's nap time is a good time for the interview, but he/she may see things differently. EMPHASIZE that you need to complete the interview before you leave and try to establish at the beginning of your visit the optimal time to do it. Sometimes it may work out better to interview the caregiver before you have finished all required observation cycles -- because the child falls asleep, the caregiver has a break, etc. If you have to make a choice between interviewing the caregiver before the 4th observation cycle and coming back to interview her at a third visit, come back for a third visit or try to interview her by phone. Just be aware that you should not be influenced in your observation ratings by any information about the caregiver's background you have discovered in the interview. Caregiver training is not a guarantee of greater sensitivity, for example. A summary of the suggested order of the observation and interview procedures is as follows:

FOR CENTERS:

First visit

Introductions, instructions, getting settled (10 minutes)

First 44 minute observation cycle: 30 minutes on Behavior Scales and 14 minutes on Qualitative Scales

5 minute break (if necessary)

Second 44 minute observation cycle

5 minute break (if necessary)

Third 44 minute observation cycle (if desired and appropriate)

Profile observation (40 minutes)

"Typical visit" questions (3 minutes)

Questionnaires -- leave to pick up at second visit

End-of-visit rating scales for first visit (2 minutes)

Second visit

Third or fourth 44 minute observation cycle (DO NOT COMPLETE ALL OBSERVATIONS ON DAY 1; at least one MUST be done on Day 2).

5-minute break (if necessary)

Fourth or fifth 44-minute observation cycle (if needed, desired)

5-minute break (if necessary)

Interview with up to 2 caregivers including:

  "Typical visit" questions (3 minutes)

  Profile interview (10 minutes)

  Background interview (15 minutes)

Pick up questionnaires

End of visit rating scales for second visit (2 minutes)

FOR HOMES:

First visit

Introductions, instructions, getting settled (10 minutes)

First 44-minute observation cycle: 30 minutes on Behavioral Scales and 14 minutes on Qualitative Scales

5-minute break (if necessary)

Second 44-minute observation cycle

5-minute break (if necessary)

Third 44-minute observation cycle (if desired and appropriate)

Profile observation (40 minutes)

"Typical visit" questions (3 minutes)

Caregiver Questionnaires -- leave to pick up at second visit

End-of-visit rating scales for first visit (2 minutes)

Second visit

Third or fourth 44-minute observation cycle (DO NOT COMPLETE ALL OBSERVATIONS ON DAY 1; at least one MUST be done on Day 2).

5-minute break (if necessary)

Fourth or fifth 44-minute observation cycle (if needed, desired)

5-minute break (if necessary)

Interview with up to 2 caregivers including:

"Typical visit" questions (3 minutes)

Child Care HOME interview (20 minutes)

Profile interview (10 minutes)

Background interview (15 minutes)

HOME completed (5 minutes)

Pick up questionnaires

End-of-visit rating scales for second visit (2 minutes)

14. Minimum Data Collection Required

At least two visits and four observation cycles are required. A cycle is 30 minutes on the Behavioral Scales (15 of actual observing and 15 of recording) + 14 minutes on the Qualitative Scales. The minimum length of a cycle will be 20 minutes (the 20 minutes will be spent doing the Behavioral Scales and the ratings for the Qualitative Scales will be based on this time). DO NOT COMPLETE ALL OF THE OBSERVATION CYCLES ON A SINGLE DAY. At least one of them must occur on Day 2.

Interrupted Cycle. If one of your ORCE cycles is interrupted by a nap, or whatever, but the case of characters (caregivers and children) and the setting remains the same when the child wakes up, you can resume the cycle where you left off. If, however, any of these factors has changed, then you must start a new cycle.

Incomplete Cycle. Any ORCE cycles of data collection which are not completed should be sent to the DCC with whatever data was collected on them. The complete cycles should not be renumbered leaving the incomplete cycle out.

15. Feedback

If the caregiver asks for feedback, assure him/her that he/she will be sent a copy of the results when the Study is completed and that, due to confidentiality, we cannot release any information about individual children, families, or child-care programs.

Only general information should be given to caregivers. Emphasis should be on our wish to capture the child's experience in the setting and not on any desire to evaluate the quality or adequacy of the center, home, or caregiver. Emphasis should be on the "exploratory" (vs. evaluative) nature of the data collection: We don't know how children's experiences contribute to their development unless and until we collect information about those experiences.

If the parent asks for information about the child-care setting, most times the person talking to the parents will not have any information about the child-care setting because a different observer will be making these visits. Parents who ask, however, should be encouraged to observe in their own daycare sites, to talk to their caregivers about their concerns, etc. They should also be told that decisions about day care arrangements are personal ones, and that what makes one parent comfortable will not necessarily make another parent happy; hence our advice is not as important as the parents' personal observations and values.

16. Flexibility

Child-care environments are rarely consistent or predictable. This requires flexibility on the part of the research assistants. It is important that -- within the constraints of the prescribed order of observation/interview procedures -- you accommodate to the caregiver's (program's) needs and schedule, in addition to the child's schedule.

17. Multiple Study Children in Same Arrangement

As part of the 24-month observations in those cases in which one study child attends the same child care arrangement as another study child, the following procedures should be followed:

1. It is desirable to have different child care observers collect the data for the children.

2. A complete set of caregiver-child interaction (ORCE) data should be collected for all children, i.e., four 44-minute ORCE observations should be made for all Study children.

3. Please use the following guide depending on the situation encountered.

4. The four months should be calculated from the second child care visit to the second child care visit.

5. In child care arrangements in which there are more than 2 study children, calculate the 4 months from the time the first child was visited.

< 4 months after initial visit and NO staff turnover:

CENTER	FDC
Director Telephone Interview_	
Center Version--	
Caregiver Interview (Short Form)	Home Version--
*6/7 Caregiver Questionnaires	Caregiver Interview (Short Form)
* When Parent Leaves	same
* When Parent Returns	
* Taking Care of Young Children	
* ASBI	
* CBCL	
* My Feelings	
	HOME

< 4 months.....................and staff turnover

CENTER	FDC
Director Telephone Interview	
Director Questionnaire (New director-Long Form; old director-none)	
Center Director Background Information Ques (New director only!)	
Center Version-	Home Version
Caregiver Interview (New caregiver-Long Form; same caregiver-Short Form)	Caregiver Interview (New-caregiver-Long Form; same caregiver-Short Form)
*7/7 Caregiver Questionnaires (for each new caregiver)	same
* When Parent Leaves	
* When Parent Returns	
* Taking Care of Young Children	
* ASBI	
* CBCL	
* My Feelings	
* Ideas about Raising Children	
Profile	Profile
	HOME

4 months-11 months, 31 days after initial visit and NO staff turnover:

CENTER	FDC
Director Telephone Interview	
Director Questionnaire (Short Form)	
Center Director Backgrd Info Quest.	
Center Version	Home Version
Caregiver Interview (Short Form)	Caregiver Interview (Short Form)
6/7 Caregiver Questionnaires	same
* When Parent Leaves	
* When Parent Returns	
* Taking Care of Young Children	
* ASBI	
* CBCL	
* My Feelings	
	HOME

4 months-11 months, 31 days....................and staff turnover

CENTER	FDC
Director Telephone Interview	-
Director Questionnaire	-
(New director-Long Form; same director-Short)	-
Center Director Background Information Ques (for new or old director)	
Center Version- Caregiver Interview (New caregiver-Long Form same caregiver-Short Form)	Home Version- Caregiver Interview (New Caregiver-Long Form same caregiver-Short From)
7/7 Caregiver Questionnaires (for each new caregiver..see above list)	same
6/7 Caregiver Questionnaires (for same caregiver......see above list)	same
Profile	Profile
	HOME

18. Taking Leave

Before you leave, thank and say goodbye to the caregivers and Director and reconfirm the next visit. Pick up the Director's Questionnaires and Director's Background Information Interview, if you haven't already. At the second visit, pick up the caregiver's questionnaires.

B. General Interview Procedures for Caregivers

This section describes the procedure for obtaining the interview data from the caregiver(s).

At the end of the second visit, you will do the caregiver interview(s). Caregiver interviews should be done after the observations, at the caregiver's convenience. You may suggest that the target child's nap time is a good time for the interview, but he/she may see things differently. EMPHASIZE that you need to complete the interview before you leave.

Reread the section on assigning caregiver ID's (see Section III.A.11, Assigning Child Care ID's, above) and be sure to match the ID's used during the observations with the ID's of the caregivers who are interviewed.

The interview is structured predominantly as a "guided" interview. Read the question to the caregiver (he/she will ideally be sitting where he/she can read along with you, e.g. side-by-side at a table) and record his/her answer. In some cases, there are several response choices. You should still record the answer(s), but in these cases, you do not need to read every response choice unless the caregiver wants you to. Rather, move the interview form in front of the caregiver and suggest that he/she read the responses and then indicate his/her answer(s) for you to mark.

The best circumstance under which to administer the interview is one in which the caregiver is not simultaneously responsible for supervising children. In most cases, however, this will be impossible. Thus, you will need to become accustomed to frequent interruptions. You will want to sit beside the caregiver so that he/she can read along with you. You (and he/she) will undoubtedly be tempted to simply let the caregiver complete the interview as a questionnaire. Our experience tells us that this produces both incomplete and unreliable data. Although most of the interview items are very straightforward, a busy caregiver will always be tempted to read and answer items quickly and, perhaps, not as carefully as possible. You will also find that there will be more questions than you might anticipate, given the individual circumstances that frequently arise (e.g., "*I haven't had any training in the last 12 months, but I spent the previous year taking a college course in child development -- can't I count that?*").

There are quite a few SKIP patterns in the interviews. Be sure to have these patterns well memorized, along with the information in the manuals that accompany each interview form, so that the interview will go as smoothly as possible.

In administering the interview, please listen to what the caregiver says and remember it from one question to the next. If he/she has already (inadvertently) answered a question in responding to an earlier one, when you come to the later question pose it in a confirmatory way (*"And you said that..."*), not as if you hadn't heard her the first time. Ditto if you see her doing something; don't act as if you didn't notice. Say *"And I noticed... do you always/ do you usually"* -- or whatever is appropriate. Use common sense, tact; be sensitive, intelligent. Also, please use language that is appropriate for the individual caregiver: if he/she considers herself a "babysitter," don't refer to her as a "caregiver" or "care provider"; if the father is not married to the child's mother don't refer to her as "your wife," and so on.

C. Which Interviews to Use When

There are multiple versions of the interviews.

1. The 4 Versions of the Director Interviews

* Director Telephone Interview -- There is only one version of this. Always complete this interview even if one has been done within the past 4 months.

- *Director Questionnaire (Long Form)* -- Use for directors who have not been interviewed before and for directors who were interviewed for the target child at 15 months.

- *Director Questionnaire (Short Form)* -- Use the Short Form if the director was interviewed for another study child within the past 4-12 months.

- *Center Director Background Information Questionnaire* -- There is only one version. Always use this interview at each assessment period. In the case of multiple study children, use this questionnaire again if the director completed it for another study child at least 4 months earlier.

2. The 6 versions of the Caregiver Interview

- *Center Version (LONG FORM)* -- Use for caregivers, including mothers, in center-based care who have not been interviewed before. Always use the Long Form if the caregiver has changed her/his place of employment, regardless of when the last interview took place.

- *Center Version (SHORT FORM)* -- Use for caregivers in center-based care who have been interviewed before. Use the SHORT FORM 1.) if the caregiver was interviewed for the target child at 15 months or 2) if the caregiver was interviewed for another child in the study within 12 months. Before you go to the center, review the responses the director/caregivers gave on the prior interviews so you will know what the earlier situation was (re caregiver training, class size, etc).

* Home Version (LONG FORM) -- Use for all home-based caregivers (including family day-care providers, nannies, grandmothers, child care providers and their paid or unpaid helpers who provide regular care at least 10 hrs/week), who have not been interviewed before. Always use the Long Form if the caregiver has changed her/his place of employment, regardless of when the last interview took place. This form is also used in the situation where a mother brings her baby to work and someone looks after him/her (not a work-site center). Some of the questions on this form have to be stretched to be appropriate for a "helper." You must take into account the primary care provider's responses. Use the following guidelines for interviewing a helper: In general, questions that provide new information should be answered. Those that ask for information about the program (policies, age of the children, etc.) should be skipped. Ask the following questions:

Section A (The Child) Answer A1-A3, A5-A8,

Section B (The Wages) answer B1, B2 (answer this question the way it is written. We will miss some "in trade" agreements between the assistant and the provider. For example, we had one assistant who worked for free in return for room and board. We also had one assistant who brought her child to day care for free as part of her pay.) Answer B6-B8.

Section C (Other children) (D,E,F,G,H) Skip entire section.

Section I (Caregiver's Background) Entire section is to be answered.

Section J (Child Care Experience) Answer J1-J5 and J8-J12.

Section K Educational Background) Entire section is to be answered.

Section L (Reasons for Providing Child Care) Entire section is to be answered.

Section M (Future Plans) Entire section to be answered.

* Home Version (SHORT FORM) -- Use for all home-based caregivers, who have been interviewed before. Use the SHORT FORM 1.) if the caregiver was interviewed for the target child at 15 months or 2.) if the caregiver was interviewed for another study child within 12 months. Before you go to the home, review the responses the caregiver gave on the prior interview so you will know what the earlier situation was (re caregiver's training, etc.)

* Home Version for Fathers (Long Form) -- Use for all arrangements in which the father is the provider. Always use the Long Form.

* Home Version For Mothers Who Are Child Care Providers (Long Form) -- Use for all arrangements in which the mother of

the target child also takes care of other children for 20 or more hours per week. Always use the Long Form.

3. Differentiating Centers From Family Day-care Home

With respect to group family day care homes, we will use the measures for home-based child care when the care occurs in space that is also used as a residential home. We will use the measures for center-based care when the care occurs in space that is not also used as a residential home (even if the building looks like a home). If there are two providers in the family day care home, collect all relevant data (observations, interviews, questionnaires) for both of them.

D. Specifics on Director Telephone Interview and Questionnaires

1. Director Telephone Interview

This is a straightforward interview, which consists of 8 questions. With respect to questions 6, 7 and 8:

* Question 6, page 4: Please get the total number of children enrolled in the room. There may be some cases where, because of part-time children, the maximum children in the room at one time is less than the total number of children enrolled in the room, e.g., 9 children enrolled, but only 7 in the room at one time due to part-time children. But, please code "9" in this

case. We get the maximum number of children at one time in question 8.

- Question 7, page 4: Code the ages of all children enrolled in the room (see Question 6, ORCE: General Procedures, Addendum).

- Question 8: This is where you code the maximum number of children at any one time.

2. Director Questionnaires (Long/Short Form)

This questionnaire asks for information about the staff, the number of children and general information about the center.

Be sure to explain on the phone how to do the questionnaire as it will be mailed to the director. If not completed when you get to the center, go over it with the director. If he/she has any questions about the questionnaires, here are some aides to answering them. Remind the director to complete the questionnaire using a soft pencil and tell her, if in doubt, to leave it until she can discuss it with you.

Information on specific questions follows:

Question A3. If a program simply rents space from a church (church-housed), they are not church-sponsored. Sponsorship implies that the church (or other entity) effectively owns/runs or pays someone else to run (as is sometimes the case in corporate programs) the child-care center. If a center is in a federal or state building and set up for government employees, it is sponsored by a "corporation/business/hospital."

Question A6. Full-day care means at least 6 hours a day. Programs that are open for 6 hours a day, but only allow children to be enrolled for one of two 3-hour sessions are part-day programs. Night care means care that accommodates shift work, e.g., past 7 pm. Sick care means care beyond the usual adjustments that are made for mildly ill children. A good indicator is a separate room where sick children can be isolated with a caregiver assigned to this room.

Question B3. This refers to the maximum number of children there on any given day, NOT the center's licensed capacity. If a center has 40 children enrolled, but has a licensed capacity for 50 children, code "40".

Question B5. Does not include cognitively slow children, unless specifically determined (by teacher, director, or other) to be handicapped or learning disabled.

Questions C1-C3. If the center uses different titles, use the following definitions and match staff to functional roles: Assistant teachers and aides: Provide care under the supervision of a more senior/experienced member of the staff. Teachers and teacher-directors: The lead staff person in a classroom, or in a cluster of classrooms. Sometimes called head or lead teachers. Teacher-directors combine administrative and caregiving responsibilities on a regular basis. Administrative Directors:

Exclusively an administrative staff member, although may sometimes substitute in the classroom if short-staffed.

3. Director-Background Information Questionnaire

This Questionnaire is also mailed to the Director before the child care visits. Remember to explain on the phone how to do the questionnaire. If not completed when you get to the center, go over it with the director.

This questionnaire asks for information about the Director's background, including training and education. It also asks for some information about the Program's funding. Because some of the questions are of a personal nature (e.g., salary), you should assure directors that their responses will be kept confidential.

E. Specifics on Child Caregiver Interview

1. Center Version-Long Form

Information on specific questions follows:

Question A3. If his/her schedule varies day by day, get a weekly average and divide by the total number of days/week he/she provides child care to CHILD. Remember this is not necessarily the number of hours the child is at the center.

Question A4. An individual assignment must be made as explicit policy. Individual assignment means that a caregiver is assigned as primarily responsible for specific individual children in the group. For example, you may have a group of 16 children with 3 caregivers. In many cases all of the caregivers are responsible for all of the children. However, some centers follow a policy whereby each caregiver is assigned to 1/3 (a sub-group) of the children as her primary charges. Sometimes these subgroups may even split off into separate small groups with their one primary caregiver for certain activities but this is not essential to the definition of individual assignment. Therefore, in cases where caregivers are assigned to subgroups give the number in the group or if individual assignments are not made give the total number.

Question A5. Do not count the cook, administrative director, etc., in a center if they do not regularly provide child care beyond their primary responsibilities as cook, administrator.

Question B4. If the caregiver has a joint custody arrangement count the children involved as "own children."

Question B6. Some children will have multiple, simultaneous arrangements over the course of a day or week. Let the caregiver circle all arrangements that are used for more than 10 hours a week.

Question C1. Write verbatim what the caregiver tells you.

Question C4. What is needed here is the hourly wage before taxes.

Question C5. If caregiver has worked less than 1 year, code the number of months she is planning to work.

Question C9. "In the field" includes activities, such as consulting, training, or working for a child-care resource and referral agency, that are directly tied to the early childhood and child-care fields, as well as direct caregiving.

For any items for which response code is in years and the caregiver's response is less than 1 year, code as 00 (e.g., length of time working in center.)

Question C13. Err in the direction of indicating "yes" if he/she names an organization that you are not familiar with.

Question E1. A high school diploma plus one college course is coded as "14". A high school diploma plus 4 college courses is also coded as "14".

Questions E3 & E4. If he/she is unaware of state certifications, then he/she does not have one. Not all states offer all of these certificates/credentials. Any certificates that are issued by the state and that are used to qualify a person as a caregiver of young children should be coded as "state certification in ECE". For example, the Massachusetts Office for Children issues Office for Children certificates which specify whether a caregiver meets the state criteria as a "teacher" or a "lead teacher". These count as "state certification in ECE".

Question E5. Err in the direction of indicating "yes" with respect to course work and training.

Question E6.

1. High school (while caregiver was a student in high school)
2. Vocational school (child care training, nannying, teacher's aide)
3. College (courses or major in child development, early education)
4. Graduate school (courses in child development, early education)
5. Adult education (at community college, university, or high school; credit or noncredit; through extension)
6. Conference or workshop (one or more conferences)
7. In-service training (offered at preschool)
8. Correspondence or television course
9. Parent education classes

Question E9. Training that is required by the state or by an employer for purposes of advancing from a teacher to a lead teacher (as in Massachusetts) should be coded as "yes", training that is required....

Question E10. If he/she cannot remember hours, get a best guess. For horizontal numbers 1 2 3 4 the top row is tens,
1 2 3 4 the bottom row is ones.

Question E12. Do not ask this question at 24 months.

Question E13. "The director lets me do it" is not considered "support."

Question F2. Do not read this out loud if there is any change - you may be over-heard.

2. Home Version - Long Form

Some of the material presented in section A on the center version apply here as well, e.g., how to code the age of the caregiver's child.

Information on additional specific questions in the home version follows.

Question A3. Use 2 hour differential as the rule of thumb for whether a schedule varies from day to day. Therefore if one day cg. does care from 9-12 and one day 9-3 code that the schedule varies from day to day.

Question A9. The skip should say N (go to question A11).

Question A10. Code in order of hierarchy - top to bottom. For example, grandfather could be 4 or 7 - code 4.

Question B2. Count free rent, parents take cg. shopping, parents make dinner for cg. etc. as "in trade."

Questions B4 and B5. Use the target child's rate if rates vary for different children. If a provider charges a set amount, regardless of whether a child comes part- or full-time then code the same rate for both questions, e.g., if he/she charges $35 per day regardless of hours, then both questions are answered with 5 x $35 = $175. If a provider charges $4.00 per hour, then full-time is 40 X $4.00 = $160 and part-time is 20 X $4.00 = $80. If the number of PT hours varies for different children, just get the hourly rate and multiply by 40 for the FT, weekly rate and by 20 for the PT, weekly rate.

Question D3. Some caregivers may not consider their nieces and nephews as children in their care. Rely on your own observations of children who are there and confirm by asking caregiver directly: "I can't help noticing Jimmy and Johnny. Who are they? Do they come here regularly?" Other caregiver's may consider live-in grandchildren as their "own" children. But for our purposes these are "other children".

Question D16. This must be more than once every 2 months - for example when parent travels etc.

Question D20. Write down what the cg. says even if this contradicts observations.

Question D24. Other caregivers may consider live-in grandchildren as their "own children". But, for our purposes, these are "other children". (Note this refers to parallel questions - see E1.)

Question D25. Please include grown children of the provider (his/her own children), but not spouses or children of these children, or children of the provider's relatives. (Note this refers to parallel questions - see E2.)

Question D26. If there is a live-in, daughter-in-law, she does not get coded as "grown children living at home". These include only children of the caregiver. (Note this refers to parallel questions - see E3.)

Questions D27 and D28. These questions refer only to children of the caregiver that are under 16 years of age.

Question D28. This is for the time that cg. is providing care for other children.

Question E6-E13. These questions refer to other children besides TC and caregivers own children.

Question I2. You may read this list and/or let them look at the list.

Questions J2-J4. Questions J2 and J3 refer to paid and unpaid child care.

Question J6. If the caregiver does not know what these terms mean, then he/she is NOT licensed or registered.

Questions J8, J9 and J10. Include nanny agencies as long as they provide the kinds of support that are asked about.

Question K10. For a college course only count classroom time not study time.

Question L2. Please code "N" for Not a reason for items that do not apply to the provider, for example the item "to see my grandchild/niece/nephew grow up" should be coded N for unrelated providers.

Question L3. Please code "1 - Not at all important" for items that do not apply, such as "to give the child a home away from home" in cases of in-home care.

Question M1. If caregiver is just taking care of Target Child until Target Child is in school and does not have any places to take care of any other children code as short term job.

3. Home Version - Short Form

Question J5. DO NOT ASK this question.

Question J6. If the provider had a license at a previous time period and there hasn't been a change code no.

Question J11 Ignore the skip pattern.

Question J13 Always ask this question.

4. Home Version for Partners

This version follows closely the Home version. It is written so that the language is appropriate for fathers and partners. When referring to the child's mother use whatever term seems most appropriate (e.g. your wife or your partner or target child's mother or Mary).

Form 11G. Change "Fathers" to "Partners"

Start by telling them that this interview does not ask about his/her employment or education because we have that information from the Mother's interview.

Throughout the interview, "child care" is defined as the time when the partner is caring for the TC while the mother is working.

Questions D1 and D2 on page 9 should be skipped at 24 months.

5. Home Version for Mothers Who are Child Care Providers

In general, it would be helpful at the outset of the interview to explain to the mother that you are interested in her role as a child-care provider for other children as well as target child.

All of these questions refer to times when the mother is caring for her child at the same time as other children.

Questions B1-B3. These questions include all children (other then TC). Can include TC's siblings.

Questions B4-B8. These questions only include other children - this does not include TC or TC's siblings.

F. Child Care Provider Packet, Child Behavior Checklist, and Adaptive Social Behavior Inventory

The child care provider packet consists of 7 questionnaires: Parent Leaves, Parent Returns, Ideas About Raising Children, Taking Care of Children, My Feelings, The Child Behavior Checklist, The Adaptive Social Behavior Inventory. Not all questionnaires will be completed by all types of childcare providers - see following guide.

	DC Provider	FDC Provider	Baby Sitter in Child's Home	Father	Mother as FDC Provider
Parent Leaves	X	X	X	O	O
Parent Returns	X	X	X	O	O
Ideas	X	X	X	H	X
Taking Care	X	X	X	O	O
My Feelings	X	X	X	X	O
CBCL	X	X	X	X	O
ASBI	X	X	X	X	O

X - YES
O - NO
H - Give Unless HHS Family

Before giving the questionnaires to the caregiver(s), remember to complete the ID information for the caregiver and the CHILD. Write in the CHILD 's name on the instruction page.

The child care visitor will leave the questionnaires with the caregiver(s) -- maximum of 2 -- at the end of the first visit. These will be collected and reviewed at the end of the second visit. If the caregivers do not have the questionnaires finished at the end of the second visit, offer to pick them up at a later date or leave a stamped/addressed envelope with the caregiver for him/her to mail the questionnaires to you. YOU WILL NEED TO FOLLOW-UP ON THIS TO ASSURE THAT YOU GET ALL THE QUESTIONNAIRES.

It is possible that some caregivers will not want to complete the questionnaires on their own. Our goal is to get the best data possible, so in these cases, work through the questionnaires -- one by one -- with the caregiver.

We strongly recommend that, as part of introducing each questionnaire, you have the caregiver read and complete the first item for each form. This will assure that he/she knows how to use the SCANTRON forms and understands the response choices. This will, of course, produce better data.

Introducing the questionnaires: A sample script:

"Here are the questionnaires I told you about. Please fill them out the best that you can. There are some items that refer to CHILD and some items about child care and child rearing in general."

"Four of the questionnaires ask you about (CHILD) and I have filled in (his/her) name to remind you of this." [GO OVER WHEN "PARENT LEAVES AND RETURNS", "CBCL" & "ASBI"] If parents alternate, ask the caregiver to respond based on the most typical/common situation. If the two parents always come by together or really alternate equally, then ask the caregiver to complete this form for the mother, since this will be most comparable with the other target children (sorry dads). *"The other three questionnaires ask about your own feelings"* [GO OVER THE "IDEAS ABOUT RAISING CHILDREN", "TAKING CARE OF YOUNG CHILDREN", and "MY FEELINGS" QUESTIONNAIRES].

"If you feel a question does not apply to yourself or to CHILD please fill in N/A (Not applicable) or make a short note. Do not leave any questions blank because we will think that you overlooked that item. Please do not write CHILD's name or your name on any of the forms. They are identified by ID number."

Instruction to the Caregiver for the ASBI:

"Here is a list of items that describe children. Please fill out this form to reflect how (target child) behaves. Fill in the box containing the number/response that best describes this child. Fill in the box containing a 1 if she/he rarely or never responds this way. Fill in the box containing a 2 if she/he sometimes responds this way. Fill in the box containing a 3 if she/he almost always responds this way. Please answer all items as well as you can. Mark CA if you cannot rate an item concerning this child.

Before you begin, do you have any questions?"

Instructions to the Caregiver for the CBCL:

"Here is a list of items that describe children. Please fill out this form to reflect your view of the child's behavior. Feel free to write additional comments in the space provided on page 2. For each item that describes the child now or within the past 2 months, please fill in the box marked 2 if the item is very true or often true of the child. Darken the box marked 1 if

the item is somewhat or sometimes true of the child. If the item is not true of the child, darken the box marked 0. Please answer all items as well as you can. Mark CA if you cannot answer an item concerning this child.

Before you begin, do you have any questions?"

"Please complete the questionnaires by yourself. We are interested in your own thoughts. Obviously, there are no right or wrong answers. Let me know if you have any trouble. I will answer any questions you may have at the end of my next visit. I will need to take the forms with me at that time (remind her of the exact date).

Thanks again!"

G. ORCE Procedures

The Observational Ratings of the Caregiving Environment (ORCE) is an instrument that examines the characteristics of the child's experiences in child care settings in two different ways: by observing the frequency of caregiving behaviors and by rating the quality of caregivers' behavior.

The behavior (frequency) scales record the occurrence of key behaviors in the following areas: positive affect, language-focused interaction, stimulation of development, behavior management, child's activity, and child's interaction with other children and child's autonomy. The qualitative (rating) scales record the caregiver's and child's behavior in the following areas: caregiver's sensitivity, intrusiveness, detachment, stimulation, and affect, and child's mood, engagement with caregiver, activity level, sociability, and attention. At the end of each day of observation, global rating scales are completed. In addition, at the end of the observation on each day, one caregiver (ideally, the one who spent the most time with the target child) is asked the post-observation interview questions.

The procedure during an observation cycle is the following:

- 10 minutes of observation using the behavior scales (following a schedule of 30 seconds of "observe" time; 30 seconds of "record" time), indicating which caregiver(s) were available and which interacted with the child during each observation interval.
- 2 minutes of note taking for qualitative ratings based on the 5 minutes of observe time during the preceding 10-minute observation period
- 10 minutes of observation using the behavior scales
- 2 minutes of note taking for qualitative ratings based on the 5 minutes of observe time during the preceding 10-minute observation period
- 10 minutes of observation using the behavior scales
- 10 minutes of observation and note taking for the qualitative ratings that incorporate the 5 minutes of

observe time during the preceding 10-minute observation period and the current 10 minutes

- completion of the qualitative ratings

RECORDING TIMES

Several forms require you to know how to record time on a 24-hour clock. This eliminates the use of am and pm. The 24-hour clock starts at 1 second past midnight with 0001 and runs to midnight, which is 2400. Here are some examples:

9:00 am = 0900
12:00 noon = 1200
2:00 pm = 1400
8:00 pm = 2000
10:30 pm = 2230

Use the 24-hour clock on the ORCE to indicate start and stop times. The start and stop times for the 44-minute observation periods are recorded on the first and last page of the ORCE form.

1. Conducting the ORCE at a Center

a. Before you start

Based on your interview with the director, you will know who the child's caregivers are, and whether they are specifically assigned to the Target Child. Mark this down on the Child Care ID Worksheet and the ORCE form so that you can confirm this once in the room. Also, find out the child's departure time and nap time for the day so you can plan how many observation cycles you can do. You will need to keep updating the ID information through-out your observations - keep the ID worksheet with you at all times.

b. Entering the room

The director will usually introduce you to the caregiver once you enter the room, but if not, be sure to identify yourself. Continue with the following script:

"As you know, I will be observing CHILD this morning. I want to see what a typical morning is like for him/her. I want to see how he/she acts around the other people in the room and how he/she pays attention to the things in the room. I want to find out what kinds of experiences he/she usually has. For the observations to be accurate, it is important that everyone act as naturally as possible and just do what they would be doing if I weren't here. I know this is easier said than done, but try to do what you would normally do. The purpose of these observations is really just to find out how children spend their time in child care. I will be following CHILD's activities, and I may, therefore, need to go in and out of the room. I'll try not to be disruptive. If you just ignore me, I hope that the children will too."

"Now I just need to make sure that I have everyone's names and positions straight." (Complete the information about caregivers at the top of the form.)

"Is (caregiver's name) (child's name)'s primary caregiver?

Is ______the lead/head teacher/caregiver for the group?

Who besides _______ and ______ has responsibility for (child)?

If there are any other adults present, who are they?"

Make sure that you know the names of the caregivers whom you will be observing (up to a maximum of eight). Try to keep your conversation with the adults and your interaction with the children to a minimum. Ask if there is a particular spot where you can sit or stand. Look for a place that is as "out of the way" as possible, and yet provides a good view of the classroom, so there will be as little need as possible to move to follow child or caregiver.

Allow 10 minutes before you begin the observation. That will allow time for the room to resume its normal routine. It will give you and the children time to "settle in." At this time children may come over to you and try to get your attention by bringing a toy or by talking. Your job is to be as neutral as possible. This means not rebuffing the child, but not being overly encouraging. It is a fine line and not an easy task, but you will find your own way that is comfortable.

c. Overview of Behavior Scales

You will be observing and recording the behavior of the target child and of any caregiver directed toward that child. Once you begin the observation period, focus on the target child. If the child leaves the room, follow her/him. If the group goes outside, accompany them. During this observation try (as impossible as it seems) not to let the target child know that she/he is being observed. This means looking at the group and avoiding eye contact with the child. As they occur, make mental note of behaviors that you know are on the checklist. Keep your attention on what is happening to the child during the "observe" period. If you are afraid you will forget some behavior that occurs, you may record it during the observe period as long as you do not miss any other behaviors that occur while you are glancing down at the record form.

Use the "record" periods to check systematically through the list of behaviors from top to bottom to make sure you have noted everything that happened. You will have 30 seconds to record your observations for the preceding half-minute. Accuracy is critical. For most of the scales, either the behavior occurred (mark it), or it did not (leave it blank). Even if the behavior occurred more than once in the interval, mark it just once. Each behavior should be coded only once in any category. A category may be left blank if no relevant behaviors occurred during the 30-second observation interval. (See page 91 for guidelines for Behavioral Scales for detailed definition of the items).

d. Overview of Qualitative Scales

For the Qualitative Scales, focus explicitly on the dimensions of caregiver and child behavior tapped by these scales. Be aware of all the caregivers who interact with the target child.

When determining who to rate on the Qualitative Scales remember that the Qualitative Scales serve to document the quality of the child's caregiving experience. The general rule for determining who to rate is as follows: the Qualitative Scales are coded for caregivers who are involved with the target child for at least two of the four 10-minute segments in a 44 minute observation. If one caregiver is exclusively involved with the child, additional caregivers will not be coded on the Qualitatives, even if they are present throughout the observation. If no caregiver is ever involved, then all caregivers present (up to a maximum of 3) will be considered responsible and all will be coded. There will still be some judgement on what constitutes "involved", but it will clearly require some indication that the caregiver is supervising, directing, or responding to the child during a 10-minute segment.

When the child is involved with a "non-caregiver" during a majority of the observation time, then the Qualitative Scales are to be rated for that adult, for that observation period (as well as any caregivers that fit the above criteria). There will not be any other data collection done on these non-caregivers and they will not be assigned ID numbers. By the same reasoning, if the head teacher does not meet the "2 segments involved" or "no one involved" criteria, then the head teacher would NOT be rated on the Qualitatives for that observation period.

Each set of qualitative ratings is to be based on a 44 minute cycle, of which 25 minutes are actual observation. During the first 34 minutes, the observer completes the Behavioral Scales and make notes for the qualitative ratings in the two 2-minute breaks. During the next 10 minutes, the observer should focus explicitly and solely on the qualitative ratings. To help observers remain on task during this time, they should take longhand notes or make preliminary ratings of caregiver or child behaviors as they relate to each scale.

In the definitions of each scale, we have avoided applying absolute frequencies of occurrence for assigning ratings. On occasion, raters will not be able to observe for the full 44 minutes. Also, frequencies may be dependent on specific activities in the child care setting. Consequently, in assigning ratings, you should use a two-step process. The first step is to ask, Is this dimension "characteristic" (a rating of 4 or 3) or "not at all characteristic" (a rating of 2 or 1) of the person being rated? Once this decision is made, then determine if the dimension is "sort of" characteristic or "very much" the case.

Ratings for most of these scales should be based on both the quality and quantity of behavior. Thus, evaluations should be made taking into account the quality of the observed behaviors in relation to the proportion of the time they were observed. (See page 117 for 24/36 Month Qualitative Ratings, for detailed definitions of the items).

2. Conducting the ORCE at a Home

The ORCE procedures will be the same in home settings (child's own home, sitter's home, family daycare). However, your experience may be different. Although the setting may seem more informal, it is important for you to remember your role of objective observer and try not to be drawn into the activities of the environment. In addition, there may be more opportunity for informal conversation. By emphasizing to the caregiver that you want him/her to act as naturally as possible and to pretend that you are not even there, you are letting the caregiver know that you need to focus your full attention on what is happening in the setting.

Basically, you will follow the same sequence as in the center except that there will usually not be multiple caregivers.

Before you begin observing, when you first get to the home, spend a little time (not more than 10-15 minutes) chatting with the provider as an introduction and warm up. Caregivers may be nervous during this procedure, and so may you. You should spend a little time at the beginning just getting acquainted with the caregiver. The conversation might be about common or mundane things that any two persons might talk about. This will allow you to get some sense of who lives in the house and what their roles are in the family. Many times there will be another child present at the time of the interview, and it may be necessary to devote some attention to that child as well as to the key child. The general tone of the interview should be that of two friendly people, who like to talk about children, sitting down together and doing exactly that. This warm-up period offers a good opportunity to say something nice about the child (refer to the child's appearance or behavior, whatever comes easily to you and can be done honestly). Not only will the compliment help break the ice, but observation of the caregiver's response may enable you to score an item such as #11 from the Infant-Toddler Scale--"Caregiver responds positively to praise of child offered by Visitor."

After the first ORCE subcycle (10 minutes) and the completion of the preliminary qualitative ratings, pause the audiotape while you tell the caregiver that this is what you will be doing for the next couple of hours. Ask him/her if he/she did anything different because you were there (didn't leave the room, didn't play with the child, etc). If she says she did, encourage her not to, but to continue business as usual as if you weren't there. Then begin the audiotape again to begin the next observe cycle.

3. Observer's Interaction with Caregivers

Whether at a home or a center, the observer should make all effort to put the caregiver(s) at ease (smiling, accepting a coffee and a chat at the end of the observation, etc.). You are a person, not a video camera (despite the fact that your observation record should be a accurate as a camera's). You have feelings, reactions, good sense and judgment that should not be left behind at the door. You should make your role as observer clear to the caregiver; you are there to watch, not to intervene (or babysit). We suggest that you state explicitly that "I am not allowed to be left alone with the children." The caregiver should behave as he/she would if you were not present. Thus, in arrangements with only one provider, the provider may need to leave some children unsupervised for brief moments (e.g., bathroom breaks) and you will momentarily be left alone with the children. On the other hand, if the caregiver asks you to watch the children while he/she makes a phone call in a different room, you must refuse politely and say that you are not allowed (for liability reasons) to be left alone with the children even if he/she would ordinarily make such calls. Clearly, if a child is in a different room from the caregiver and is in imminent danger, you cannot stand by and watch it happen. You must find ways of ensuring that your presence, including your nonintervention, is not affecting what is going on in the room (e.g., older children hitting you or each other because you are so unresponsive). It may help put caregivers at ease if you say something about the unusual role of an observer who is basically not allowed to act naturally herself.

Try to put the caregiver at ease by reassuring her you are interested in observing a **typical** day, and that you will try to be as unobtrusive as possible. Avoid eye contact with the caregiver and the children so as not to invite conversation or interactions, and try to keep your facial expression neutral. If the caregiver seems eager to talk, tell her there will be time during the interview to cover that particular issue, and make a note to talk about it later -- "I'm afraid I won't finish up in time; let's discuss that later during the interview" might be a helpful deterrent. Also, remember that the closer you are to the caregiver, the more likely it is that you will influence her behavior, so try to find a "vantage point" away from the caregiver from which to observe.

4. Specifics on Behavioral Scales

a. Page 2 information

Available adults: Code the number of adults (over 12 years of age) who are in the same room as the child or, particularly in home settings, within earshot of the child, even if not in the same room. They are not necessarily paying attention to the child; they may be involved with their own activities or with other children. Code this at the beginning and at the end of the observation cycle. When the child is out of his/her regular care setting (i.e., the home or center), a more "functional" definition of "available" must be used. Adults standing in a check-out line at the store or bank or library should not be counted. There must be some likelihood that these people would interact with the child; they must be part of some functional "group" of which the child is also part (as would be the case if they were in the child's class at a center or in the child's home). The reasons to make this distinction are (a) to make the coding for parks, etc. more comparable to the coding for centers and homes, and (b) to use the coding as the basis for calculating meaningful adult-child ratios. If the park or playground is, in fact, a regular child care setting -- that is, the caregiver takes the child there everyday and they see and interact with the same people there everyday -- then the "functional group" would consist of those adults and children that they see and interact with every day.

Describe each of these adults as a caregiver, friend, volunteer, target child's parent, other parent, etc. For the purposes of the ORCE, a caregiver is defined as anyone who provides regular (at least 10 or more hours per week) care to the target child, or, in the case of group care, in the target child's room. The caregiver may or may not be specifically assigned to the target child. In group care this includes "floaters" who are regular caregivers in the program but divide their time across multiple rooms as long as they typically spend at least 10 hours a week in the target child's room. Some programs will explicitly define caregivers as floaters; others will not. This doesn't matter for our purposes. "Caregiver" also includes "student" teachers, parent volunteers, etc., who may or may not be paid, who spend at least 10 hours per week, at regular times, in the target child's classroom. "Caregiver" excludes any adult who does not spend at least 10 hours a week, at regular times, in the target child's classroom, such as a center director who periodically passes through the classroom, a parent in a parent co-op who volunteers for less than 10 hours a week, a music teacher (who will undoubtedly spend less than 10 hours a week in the target child's room), etc. These non-caregivers are "other adults" and will be coded on the line for caregiver 8. A maximum of 3 caregivers on the qualitatives will be coded. Up to 8 "caregivers" will be assigned ID numbers. If "other adults" (for example, you find out after the observation that people you coded as caregivers do not provide care for 10 hours per week for the TC) are coded on the behaviorals, they can be given a place holder (i.e., dummy) ID number such as 0000004, 9999995 etc.

Available other children: Code the number of children who are in the same room as the child. If there are no other children code 00. They may not be paying attention to the child; they may be involved with their own activities, but they are, at least, awake and visible to the child. Children in the park, playing on the swings, running through the grass, minding their own business while the target child is in a stroller next to the caregiver should not be counted as available. Code this at the beginning and at the end of the observation cycle. See b. Adult Available and Adult Interacting in this section.

Number of children present who are under 12 months of age.
Number of children present who are 12-18 months of age.
Number of children present who are 19-24 months of age.
Number of children present who are 25-36 months of age.
Number of children present who are 37-48 months of age.
Number of children present who are 49-60 months of age.
Number of children present who are greater than 60 months of age.

Asleep children: Record the number of children for whom the adult is responsible who are not "available," but sleeping. Although these children are not available partners for the child, they may affect the caregiver's availability.

Preamble to the ORCE Behavior Scales for experienced 15-month observers:

There are a number of significant differences between 15 and 24/36 month ORCE schemes. The following is a brief summary of the similarities and differences between the two forms. Please note that there are certain kinds of behavior that you did code at 15 months that you will not code at 24/36 months, and vice versa.

15-MONTH SCALES

Adult Available: same

Adult Interacting: same

Responds to negative affect: This scale has been dropped because child distress is less frequent and responsiveness to it less predictive of child development at 24/36 months.

Shared positive affect: This scale has been incorporated into the broader new scale "Mutual exchange."

Positive physical contact: same (but in a different overall category)

Responds to child's vocalization: This scale has been fine-tuned for older and more verbal children: it is now "Responds to child's talk" rather than simply any vocalization.

Speaks positively to child/ren: same

Speaks negatively to child/ren: same

Reads aloud to child/ren: same

Asks question to child/ren: same

Gives direction to child/ren: same

Other talk to child and Other talk to group: These scales have been combined: with all the distinctions you are already required to make, it seemed that this one was something we could afford to lose.

Stimulates cognitive development: An important change has been made in this category: the broader "stimulates cognitive development", which people seemed to have some trouble observing reliably, has been replaced by the much more focused and specific scale "Teaches academic skill." We are hopeful that this scale will be observed with ease and complete reliability as it involves no judgement or inference; and that it will provide a sampling of cognitive stimulation that will be informative both for it's own sake (a particular kind of cognitive stimulation) and as a proxy for the more general category of cognitive stimulation.

Stimulates social development: A parallel change has been made in this scale for the same reasons: the more general stimulates social development has been replaced by the more specific "Teaches social rule." This means that you will not be coding the caregiver's efforts just to get kids to play together but her efforts to get them to play together well.

Facilitates child's behavior: This scale has been dropped, in the interests of reducing the number of scales. Some aspects of it, however, now appear in the "Mutual exchange" scale, specifically, its responsive and entertaining aspects.

Uses negative physical actions: combined with the physical component of Restricts child's activities into a scale labelled "Negative/restricting actions."

Restricts child's activities: This scale, as such, has disappeared. Its verbal component is being picked up in "Speaks negatively" and "Gives direction" and its physical component is in the scale "Negative/restricting actions."

Restricts in physical container: This scale has been dropped; it is likely to be less frequent at 24/36 months, and something had to go!

Activity Setting: This category has been moved to the top of the form because it will be observed only once per interval, at the beginning of the 30-second period.

Physical care: same

Other activity with objects: same

Other activity without objects: same

Watching/unoccupied/transition: same

Watching TV: same

Child's interaction with other children

Positive/neutral interaction: essentially the same

Negative interaction: same

Says no/refuses: same

Acts defiant: same

24-MONTH SCALES (NEW)

Child talk

Mutual exchange

Teaches academic skill

Teaches social rule

Mutual pretend play

Child Behavior:

Prosocial act

Negative act (nonaggressive)

Verbal aggression

Physical aggression

Complies with adult

b. Specific Scales

ACTIVITY SETTING

At 24/36 months (unlike 15 months), one and only one activity setting code will be checked for each 30-second observation interval. At the beginning of the 30 second period, indicate which one of the following activity settings the child is in at that moment. If the Target Child is in transition between two activity settings, wait until the transition is over before you code the activity setting.

With adult (and child/ren)

The child is part of an activity in which an adult is involved. The child and caregiver may be alone, and the interaction one-to-one, or the child may be part of a group of interacting children and adults. The caregiver may or may not be attending to the target child exclusively, but he/she must at least be involved with him/her (eye contact, physical contact, verbal contact). Just visual supervision from a distance is not sufficient to receive this code. If the caregiver is physically very close to the child (within the caregiver's arm's reach; i.e., 2 1/2 feet) and watching the child (even if she is not talking to the child), or if she/she is pushing the child in a carriage or stroller, or if he/she is at or on the same piece of equipment (e.g., table), this would be coded on this scale. If the caregiver is "vegging out," or has her back to the child, even if she is physically close to the child, this would not be coded. If the child is playing with other children and the caregiver is watching from a distance but not interacting with them, this would be activity with child/ren not activity with adult and child/ren.

With child/ren only

The child is playing with another child; they may be playing in parallel, i.e., with the same materials, interactively, imitatively, or cooperatively. Or the child is playing on the same piece of equipment (slide, swings, sandbox, sandtable, table) as another child. Or the child is within 2 1/2 feet of another child (the two children's arms' reach). The children may be eating in adjacent chairs, sitting on adjacent toilets, or painting at adjacent easels, but they are not back-to-back; the target child must be able to see the other without turning around.

Alone

The child is neither near (within 2 1/2 feet) and facing nor involved with another person (child or adult). This is the default category. If the child is not clearly involved with another person, then code "alone."

ADULT AVAILABLE

For each 30-second period indicate which adults (caregivers) were available (in the same room or able to hear the child). On each ORCE page of a given ORCE cycle, the person labelled as "Caregiver 1" or "Caregiver 2" must be the same person; i.e.,. if Sally Jones is Caregiver 1 in the first ORCE 10-minute segment, then Sally Jones must be Caregiver 1 in the third ORCE 10-minute segment and on the Qualitative Ratings at the end of that cycle. To keep the caregivers straight, write a mnemonic for each (red curly hair, tall blonde, Sally, etc.) Include all adults (over 12 years) who are available here. Code each person on a separate line if they are defined as caregivers. Only caregivers will be coded on the qualitatives and will be assigned IDs. We have allowed room for up to 8 different caregivers for a cycle. If you run into situations where more than 8 different caregivers are available during a single ORCE cycle, use the "Caregiver 8" slot for all of these "extras." An adult talking to the target child on the phone is not available. The caregiver 8 slot is also used for all those people ("others") who come in and out of the situation you are observing and who are not caregivers in the eyes of the Study (caregiver = someone who provides care for the TC for ten hours or more per week). If someone enters the arrangement and you don't know if they are a true "caregiver" then put them in a caregiver slot, on a separate line, and ask at the end of the ORCE. If you know from the beginning that they are not caregivers (i.e. the mail carrier) then put them into slot #8. At the end of the ORCE cycle ask about the unknown people and determine if they are considered caregivers or not. People who are not caregivers will get a place holder ID number such as 000000 or 999999.

Example for a HOME/FDC arrangement - You are about to enter a child care arrangement in which the TC is cared for by her grandmother. You know that she will be in the caregiver #1 slot.
Caregiver #1 = Grandmother

So you start the ORCE with the grandmother in the slot labeled Caregiver #1 on the Behaviorals. The caregiver's daughter comes in after you have started. She is home from school that day and you know that they all live together (including TC) so you are not sure of this person's status vis a vis the TC. So you put her down on the caregiver #2 slot. Then the mail carrier comes to drop off the mail and stops to say hello, she gets put into the caregiver #8 slot, because you know she does not provide 10 hours or more per week of care. At the end of the ORCE you probe and find out that the daughter does not provide regular care to the TC for ten or more hours per week. Therefore you rate caregiver #1 on the Qualitatives and then put her ID on page 10. For caregiver #2 and #8 you can put a place holder ID, so that you know these people were not caregivers after all - 0000000.

Example for a CENTER arrangement - You are about to enter a center arrangement. You know there will be three caregivers that will be involved in the target child's care while you are at the center doing your observation. You give these 3 caregivers temporary ID numbers.

At the beginning of your first ORCE cycle only 2 of these caregivers are in the room, you put them into slot caregiver #1 and #2 respectively. After you begin coding, the director comes in to visit - you put her into the caregiver #3 slot. Then a parent of another child enters the room to visit his child. You put him into the caregiver #8 slot. Then the third regular caregiver comes in to start her shift, you put her into caregiver #4 slot. Then a caregiver from the next room comes in to help out for a few minutes, she gets put into the caregiver #5 slot. You continue this way adding people as they enter until you don't have any lines left. Then anyone else also gets coded on the caregiver #8 slot as well as all the "others". At the end of the ORCE you put all of these people on your temporary ID sheet. Then ask who all of these people are and figure out who needs actual ID numbers (who is a true "caregiver") and who will get place holder ID numbers.

At the beginning of the second ORCE, everyone has left the room except the 3 main caregivers. You will start this ORCE with them in slots #1, 2, 3, etc.

ADULT INTERACTING

Code which adults interacted with the child during the 30-second interval. Code a caregiver as interacting even if she merely shouts "coming" from the other room, if that "coming" was coded as "Responds to child talk" or "Other talk." If "With adult" is coded for activity setting, "Adult interacting" would also be coded, even if the caregiver doesn't actually "interact" with the child. An adult talking to the target child on the phone is interacting.

LANGUAGE

Child talk

The child says something to someone (anything to anyone). The utterance must be in words, or clearly communicative sounds. It must be directed toward someone (adult or child), not just talking to him/herself (or an animal) when he/she is alone. The target of the talk may be the observer if it is clearly directed to him/her. The child may be singing as part of a group activity but not just singing to herself. This can be double coded with

Child Behavior scales (verbal aggression, prosocial act, says "no").

Adult language

All other language coded in the ORCE is language by the caregiver (i.e., any adult) to the target child -- either alone or as part of a group of children. Each of the caregiver's utterance is coded on only one language scale except for responds to child's talk. Behavior recorded on this scale (responds to child's talk) must be coded on one of the other language scales as well. The order in which the scales are listed is the order of priority for coding. Language scales must not be double coded with each other but may be double coded with scales in the adult stimulation category.

Responds to child's talk

The caregiver listens to the child's words or attempts to say words and then responds verbally. She is responding to what the child has said, not what he/she is doing. Example: the child says "Uh, uh," pointing to a dog and the adult says "Doggie. That's a doggie." Child says "Uppy." and the caregiver responds "Shall I pick you up?" The child says "Me go." and the adult says, "You want to go out?" If the child articulates specific words, the caregiver uses the same words, corrects the child's pronunciation, extends the child's utterance, or answers the child's question. Simply imitating the child's nonverbal vocalization would not be coded here or on any other language scale. This is supposed to be a measure of "high quality" caregiving: the caregiver is responding to the child's talk in a way that might conceivably extend, enhance, or encourage the child's language. The child may grunt and point meaningfully, rather than clearly articulating a word, but in order to be coded on this scale the caregiver has to speak back to the child, not grunt back. She also is not coded if her response to the child's talk is "Shaddup!" This would not encourage the child's speech -- quite the contrary. A response like this that inhibits or stops the child from talking is not coded as responds to child's talk, even though, it is, literally, a response to the child's speech.

Speaks positively to child/ren

The caregiver says something warm, affectionate, or complimentary to the child or the group of children of which the child is a part, e.g.., praises, says "I love you." "You're such a cutie." "Hurray! Yea! You did it!" "Oh, look at how well you're climbing those stairs -- all by yourself." "Good girl." "You silly!!" "Oh, you fat little toad!!" The utterance may be warm in tone of voice or content of utterance. If in doubt, do not code; the utterance should be clearly positive; e.g., not just a "Thank you."

Speaks negatively to child/ren

The caregiver/adult says something negative to the child or the group of children of which the child is a part: finds fault, threatens, speaks with hostility; snaps, insults, scolds, criticizes, yells. Either the caregiver's words or her intonation is negative. Examples: "Are you dirty again??? I just changed you!" (said harshly) "Stop dragging that blanket all over the house right now!" "Did you hit Mary? Shame on you!" "Stop that right now. Wait till your mother gets here!"

Reads aloud to child/ren

Caregiver/adult reads from book, magazine, paper, or any other written material to the child or to the group that the child is part of. This can be reading single sentences or a complete story, but it is definitely reading, not just pointing at pictures in a book. The child may or may not be listening and learning; the point is only that the caregiver is reading and the child is there. Examples: reading a story at circle time, reading as child falls asleep, reading poster on wall to child. (Reading is reading.)

Asks question to child/ren

The caregiver asks the child a question. Any question, regardless of content, should be coded. Examples: "Are you hungry now?" "Are you excited to see daddy?" "Do you want me to tickle your tummy?" "Who is that? Is that your daddy?" "Where is your nose?" "What do you have?" "Do you want a turn on the swing?" The child may be alone or part of a group but must at least potentially have the opportunity to respond to the question. Include tag questions.

Gives direction to child/ren

The caregiver tells the child to do something or not do something. She gives an order, demand, command, prohibition, or request. "Put them in here." "Go pick up your coat." "Put on your shoes, please." "Here, color with these crayons." "Go find your brother." "Say 'kitty'." "No!" "Keep the crayons on the table." "Take that out of your mouth." "Turn the shirt right side out." "Stop fighting." "Come back here, you are not going out." The demand may be for an action that the child is willing to do or unwilling to do; the child may comply with the request or not comply (the child's compliance is coded under Child's Behavior as "Complies," "Says 'no'/refuses," or "Acts defiant"). This scale does not include indirect demands or suggestions: "Why don't you...?" "Shall we....?" These would be coded as "Asks question." The direction must be for an actual action that the child can do, not a change in the child's emotional state (e.g., "Don't cry." "Don't worry." "C'mon, smile." "Have a nice day.") Gives direction is directing the child's activity, not describing it ("Let's go in now." as they are going in), or comforting the child ("Don't cry."), or giving a general warning ("Be careful." "Don't fall."), or simply drawing the child's attention to something (e.g., saying "Oh, look at the picture of the ..." when they are looking at a book.) "Look at the ..." is considered a suggestion (i.e., other talk), not a direction.

Do not code directions that are in songs (For example, If You're Happy and You Know It, Clap Your Hands). This would be coded as Other Talk.

Other talk to child/ren

Caregiver directs an utterance to the child individually or as part of a group that has not already been coded as speaks positively or negatively, reads, asks question, or gives direction. The utterance should contain words not just sounds. A single sentence will do. Examples: "Let's go outside." "The bottle's empty -- no more." "Let's put your bib on." Singing also would be other talk. If the caregiver is singing along to a record, this would be coded as other talk to child only if it is directed to the target child; the caregiver would have to be looking at the child, possibly holding the child, not vacuuming or doing the dishes or looking out the window. If the observer cannot hear what is being said clearly, code it as other talk.

STIMULATION

These scales are mutually exclusive; do not double code the same behavior more than once within this category. However, it is quite possible that more than one of these types of behavior would occur within a 30-second period; code each of the different scales that apply.

Teaches academic skill

Caregiver teaches, encourages an academic skill. Academic skills involve the 3 R's: reading, writing, and rithmetic. Specifically, include all activities that involve numbers, shapes, letters, or colors. These activities would include counting (or adding, subtracting, multiplying), naming shapes (this is geometry!), saying (or singing, or reading) the ABCs, pointing out letters or words in a book, spelling, teaching how to read, building with alphabet blocks and labelling them, making playdoh shapes with alphabet cookie cutters and labelling them, labeling or discussing colors, teaching about shapes by showing the child how to put together a puzzle, matching objects, teaching how to make shapes with scissors, crayons (but not just showing how to use scissors or crayons). The teaching must be directed toward the target child. The child may be alone or in a group of children who are receiving a "lesson." The interaction may be playful and enjoyable (e.g., singing the ABCs), or serious and didactic (e.g., Distar).

Teaches social rule

Caregiver teaches a social or moral rule. The content of the social rule may be about sharing, turn taking, hitting, swiping toys, saying "please" and "thank you," giving compliments, expressing feelings of anger or distress verbally rather than physically, showing affection, comforting, working together (cooperating), or ownership/possession. The style of the teaching may be saying "Do it." or "Don't do it." or "I like the way you did it." or "I don't like the way you did it." (But it must be more than a simple "No.") The teaching may or may not include actions (demonstrating, restricting, etc.), but it has to include language or signing. Examples: telling the child to take turns with other children on a slide, suggesting that the child pull another child in a wagon because he would enjoy it or because it is his turn, encouraging children to share, cooperate, take turns, with each other, forbidding child to hit another child, take his toys away, etc. "Be careful you might knock baby over." "I really like the way you shared your ball with Jimmy!" "Say 'thank you.'" "This is Nate's toy and this is David's" (giving a toy to each after David has been trying to take Nate's toy). "That's his playdoh; here is yours. Play with this." "Use your words. Don't hit/cry/push." The caregiver may be teaching the social rule to another child with whom the target child is interacting. The target child may be part of a group of children that is being taught the social rule. But if the caregiver directs the rule to another child in the group by name and the target child is not part of the interaction or paying attention, this would not be coded.

Positive physical contact

The caregiver and child have positive physical contact. The caregiver holds or touches the child -- warmly and comfortingly, affectionately, or playfully. Positive physical contact includes the caregiver's holding the child on her lap, but it is not simply picking the child up to move him/her somewhere and it is not having the child simply sitting on the caregiver's lap and the caregiver not touching the child in any other way. It may occur in the context of caretaking, but it is not routine caretaking alone. It must be active, intentional (not simply touching the child's arm in passing or patting the child's behind repeatedly and absentmindedly while doing something else.) Examples are hugging, kissing, rubbing, stroking, tickling, rocking, swinging, clapping, patting, holding close, hugging, cuddling, rubbing noses, holding in arms while feeding, holding on lap. If the child does the positive physical action to the caregiver and the caregiver ignores it, this would not be coded here.

Mutual exchange

Child and caregiver are engaged in a mutual, two-way interaction in which each person does at least one positive/neutral behavior toward the other (directly or as mediated by materials or a game) in the 30-second observation interval. They laugh or giggle together, just having fun. They play a game together in which both are participating. The caregiver gives the child a toy and the child takes it and plays with it while the caregiver talks about it. The two play with the same object and talk to each other about it. The caregiver entertains while the child watches and laughs -- or vice versa. The caregiver responds to the child's bid by giving him materials that he then uses, or helping him with materials he is having trouble with and then continues playing with. The child gives a book to the caregiver, which she then reads while he listens. The child and caregiver engage in mutual pretend play.

The two do not have to be in direct physical contact or proximity but they do have to be involved with each other. The interaction does not have to be one-to-one; it may involve more than one child or more than one adult. This can occur in the group context if the child is showing active participation contingent on the caregiver's behavior (e.g., if a caregiver is playing with several children and child is participating in the game). The interaction may occur in the context of physical care, if the caregiver and child are playing a game with the food or potty. The interaction may be initiated by the child or the adult. The interaction must be mutual, responsive, and contingent. It can be nonverbal or verbal but if it is verbal it must include other elements -- either positive affect or materials (it can't be verbal alone). It must include more than "Caregiver gives, child takes" or "Caregiver says, child does" -- look for three parts to the interaction: e.g., "Caregiver gives, child takes, caregiver talks." In brief, look for the following cues to a mutual exchange: contingent responding, back-and-forth interaction, positive affect, materials.

PHYSICAL CONTROL

Restrictive actions

The caregiver uses negative physical actions with the child. These include both harsh, punitive negative actions like hitting, shaking, slapping, smacking, yanking, pinching, pushing, kicking, or putting in a physically aversive situation (e.g., out in the cold) in order to punish or control the child. They also include more moderate forms of physical restriction, like putting the child in time out, blocking the child's movements, taking away a toy the child is playing with, holding the child so he/she cannot move, removing the child from an activity he is enjoying, tapping on the child's hand or head to "remind" him that he is not to do something, pulling him away from a place or activity. This is a negative category. It would not be coded in the context of play unless the child clearly didn't want to play. It would not be coded in the context of physical contact or care unless the child was trying to escape or do something else (wriggling, fussing, reaching, etc.). Code in each 30-second segment that activity is restricted. This should be coded according to the caregiver's action rather than the child's reaction to her behavior. It must be clear that the child's activity/wishes/desires or potential activity/wishes/desires are being thwarted, but it is not necessary that the child respond to the restriction negatively (although if he/she does, it is even easier to see that it is a restriction). Some children respond to restriction negatively; others ignore the restriction and turn to other activities. For both, their activities have been physically restricted. What would not be coded would be physically holding the child in a hug that the child is enjoying, or taking away a toy that the child is obviously through playing with. If the caregiver is redirecting a child who is in a predicament (e.g., about to fall down the stairs), this also would not be coded. If the child is restricted in a care seat, this would not be coded.

CHILD'S ACTIVITY

All the child's activities that last for at least 5 continuous seconds are coded on one of these scales. There can be more than one for each interval if more than one activity occurred for more than 5 seconds. Only if no activity in the interval lasted 5 or more seconds would this category be left blank. With one exception, the activity scales are mutually exclusive; a single activity cannot be coded on more than one of these scales. The exception is watching TV. This scale may be double coded with another scale in this category. For activities other than watching TV, if an activity seems to fit more than one scale (e.g., the child is engaged in activity with objects interspersed with brief intervals of watching), code it at the highest level observed (i.e., in the order of priority in which the scales appear on the form). If the child is eating and also talking to the caregiver about going to the zoo, or if the child is dressing and singing with the caregiver at the same time, these would be considered two activities (physical care and without objects), and both would be coded.

Activity with objects

The child is involved in an activity with an object or objects. These objects would include books, toys, paints, kitchen utensils, pets, food that someone other than the child is eating, playground equipment (swings, slide, trampoline, jungle gym), tricycles, water in a swimming pool, even dirt and sand -- if they are being used as objects (i.e., the child is playing with them, building, experimenting, exploring). The object must be in the child's hands, or it must be within his/her reach and the child clearly involved with it. The child is interested in the activity, not just passing time. He is exploring, manipulating, or playing with the object. Regarding strollers, if the stroller is moving or if the target child is manipulating the stroller, code as objects. Swings and mirrors are coded as objects. If the target child is in a car, ignore the fact that the child is in the car just look at what the child's activity is.

Activity without objects

The child is involved in an activity that does not involve objects, e.g., singing songs, gross motor activity (running, jumping, walking on a line), rough and tumble play, listening to a story (but not holding or looking at the book), playing a game, holding an infant, tickling the caregiver (or vice versa). "Pretending" about non-existent objects is without objects. Talking about objects that are not actually present or touchable is without objects. Being pushed in a stroller is with objects; sitting in a stroller is without objects. Carrying or holding the child on the lap, holding hands are included.

Physical care

Child is given physical caretaking by caregiver or engages in physical care activities by himself. Physical care activities are those necessary to take care of the child's physical needs. Examples: dressing, diapering, going to the bathroom, going potty, washing, taking a bath, feeding, eating, drinking, rocking to sleep, putting on a sweater. Physical care does not include giving the child a pacifier or a wipe of a nose that lasts less than 5 seconds. Code this activity from the beginning, e.g., when the caregiver says "Let's go sit on the potty." until the end, e.g., the child is off the potty and dressed again.

Watching/unoccupied/transition

The child is awake, but not engaged in any observable activity. He may be waiting for the next activity to start (before eating, before going out), or he/she may be watching other people (adults or children) but not interacting with them. The other people are ignoring the child. They may be across the room or close up, but they are clearly not interacting with the child. It may be the observer who is being watched by the child. The child may be watching an event or object at a distance, but he cannot reach the object and no one is talking to him about it. The child is not doing anything else at the same time (using or exploring a toy, interacting with anyone, being held). He/she may be holding a toy in his/her hands or mouth, but is not exploring it. He/she may be wandering around the room or walking from one place to another but not running or jumping in fun. He/she may be alone in the crib and falling asleep. He/She may be in "time out." He/She may be sucking his thumb or a lollipop but is not exploring them. He/she may be near other children or adults or alone.

Watching TV

The TV is on and the child is looking at it. Do not code if the TV is simply on throughout the visit. Code only in those intervals that the child watched the TV for at least 5 continuous seconds.

CHILD'S INTERACTION WITH OTHER CHILDREN

"Other children" are children under 13 years. For this category, first decide "Is there peer interaction?" (parallel play is not peer interaction). Then decide, "Is the interaction (a) mutual pretend, (b) negative, or (c) anything else."

Mutual pretend play

The target child engages with another child or children in fantasy play, make believe, pretense. They use materials symbolically -- pretending that a sprinkler is a waterfall, "drinking" from empty cups, "meowing" like kittens, constructing balls or snakes out of playdoh and playing with them as if they were balls or snakes instead of playdoh (they throw the "ball," wiggle or "hiss" the "snake"). They play house, doctor, school. There must be at least two children involved; they must be interacting, not just playing pretend in parallel; they must both be pretending, not just one of them; and it must be clear they are pretending (using materials symbolically or playing roles not just using pretend-type materials such as dressup clothes). For block and playdoh play, the children must say they are making a "tower," "snake" etc., not just pile blocks into a tower shape or roll the playdoh into a snake shape.

Negative interaction

The target child gives or receives a negative -- unfriendly -- overture from another child or children: verbal or physical aggression or negative act. The target child may be the victim or the initiator of the negative interaction.

Positive/neutral interaction

Any positive or neutral social interaction with a peer or peers that has not been coded as mutual pretend. The child gives or receives any social overtures from other children -- e.g., playing with the same object, offering an object (even if it is not accepted), mutual smiling, sharing a toy, taking turns, playing cooperatively, This includes both high level, cooperative engagements between children and relatively simple attempts at interaction. Accidental bumps etc. should not be coded.

CHILD'S BEHAVIOR

Do not double code scales within this category.

Prosocial act

The child helps or expresses sympathy toward another person (adult or child). He/she gives the other person a toy (as a "gift" not as part of play or in response to a request). He/she comforts, hugs, cuddles another person (including hugging back after the other initiates a hug, but not including a hug initiated by the other.) It must be clear that the target child has initiated the prosocial act. The act must be clearly positive, not just social.

Negative act (nonaggressive)

The child makes an unfriendly but not aggressive act toward another person (adult or child) -- e.g., taking away toy that child wanted or was playing with, interfering with other child's activity, attempting to take something away from other child forcibly (pulling hard, removing the other child's hand from the toy), saying "no", "mine" to other child, yelling or whining "mine" to other child or adult, sticking out tongue at caregiver. Accidental bumps should not be coded. The act should be deliberate, but its intention should not be to hurt the other person.

Verbal aggression

The child says something aggressive -- name calling, teasing, jeering, derogating, threatening -- to another person (adult or child). Do not include fantasy aggression (e.g., pretending to shoot another child with a mock gun -- "Bang, bang!") or playful aggression (verbal aggression that is clearly playful -- all participants are usually smiling or laughing or clearly enjoying themselves.

Physical aggression

The child does something aggressive -- e.g., hitting, kicking, fighting, banging, biting -- to another person (adult or child). There is a physical attack or threat. Do not include fantasy or playful aggression (e.g., pretending to shoot another child with a mock gun) or playful aggression (e.g., two children rolling on ground together laughing and smiling while grabbing each other; two children exchanging mock punches and laughing).

Complies with adult

The child complies with a direction or suggestion that has been coded as Gives direction, Speaks negatively, Asks question, or Other talk. Examples: the caregiver says "Show me the box." -- and the child does. The caregiver says "Go get the box." -- and the child does. The caregiver says "Where is the box?" -- and the child goes and gets the box. The child must at least start to comply within the 30-second interval in which the request/suggestion/order was given, but the behavior may be completed in a subsequent interval. It would not be coded as complies again in the subsequent interval if it was coded in the first. Do not code complies to a nonverbal suggestion by the caregiver.

If the child complies with a song (coded as Other Talk) code complies. For example, Caregiver singing "If You're Happy and You Know It, Clap Your Hands" and the target child claps hands.

Says "no"/refuses to adult

The child exhibits autonomy or assertiveness by saying "no" or "mine" or some other emphatic but nonangry expression, verbal or nonverbal, when the caregiver gives a direction or suggestion, speaks negatively, introduces an activity, etc. For example, shaking head "no," holding object tightly to self, turning back to caregiver, or not doing what the caregiver requested, but without acting angry or defiant. Must be a deliberate refusal, within the 30 second period, not just ignoring the caregiver's direction as if the child didn't hear or understand. The child's refusal may be polite or whiny, but it is not angry.

If the Target Child's negative behavior towards a caregiver is in response to a caregiver's request or command then code it under the appropriate category - either Says No or Acts Defiant. If the child's negative behavior is not connected to a command or request given by the caregiver then code it under Negative Act or Physical Aggression.

Acts defiant to adult

When the caregiver tries to control the child, through a direction, prohibition, suggestion, question, or physical action, the child acts defiant: angry, yelling, aggressive, or intensifying the prohibited behavior.

5. 24-/36-Month Qualitative Ratings

a. Caregiver ratings

Sensitivity/Responsiveness to Distress

This scale focuses on how the caregiver responds to the child's cries and other expressions of distress (including temper tantrums, but not tearless anger directed to peers or even to caregiver.) It is judged in the following three ways:

1) Proportion of distress signals responded to. What proportion of distress is responded to.

2) Latency of response. How long does it take the provider to respond.

3) Appropriateness of response. Appropriateness of the adult's behavior might be inferred by its effectiveness in soothing the child as well as the completeness of the response should also be taken into account. For example, a caregiver who responds distally (e.g., voice from the other side of the room) should not be judged as sensitive as a caregiver who approaches and/or physically comforts the child. Caregivers who do not acknowledge distress should be judged as less sensitive than those who do acknowledge the distress, however short lived. Caregiving responses to child distress generally involve speaking sympathetically to the child, approaching the child, distracting with toys or activities, hugging, patting, picking up, or holding in lap and rocking. For toddlers, physical contact is not always the most effective or even the most appropriate response to distress. Much depends on the intensity and cause of the distress. Calm reassurance, explanations, or negotiations are appropriate responses when the distress has a clear, explainable cause. When the cause of distress is unknown, the sensitive caregiver will try to determine the cause by asking the child. In addition to reassuring the child, the sensitive caregiver will also attempt to alleviate the cause, where possible (e.g., speak to another child who was the cause of the distress; help with a frustrating physical world problem). Any of these or other behaviors can be considered sensitive if they appear to have the effect of soothing the child. If the caregiver's first response

to the distress does not soothe the child, which will happen more often with toddlers than infants, the sensitive caregiver should offer a "fuller" response or adapt a different strategy (i.e., more proximal soothing behaviors).

Ratings on this scale are composed of both qualitative and quantitative dimensions. The proportion of signals responded to and the latency of response time should be evaluated in relation to the quality of the response. For example, if a caregiver responds very slowly or not at all to the child during the 44 minutes of observation, he/she should receive a rating of 2. A caregiver might receive a 3 if full responses are delayed or immediate responses are somewhat "shallow" or if there is a combination of such responses. A rating of 4 should be given to those caregivers who exhibit immediate and exceptionally sensitive and appropriate responses.

If a caregiver other than the focal caregiver responds to the child's distress, it is not expected that the focal caregiver respond. These instances of distress should not be considered in evaluating sensitivity to distress.

1 = Not at all characteristic. This rating should be given to caregivers who are very insensitive and unresponsive. When the child is upset, the caregiver responds not at all, or very slowly or inappropriately. If there is a response, it is only after the child becomes very demanding, and the response is so delayed that it cannot be construed as

contingent upon the child's behavior. A caregiver who typically appears oblivious or punitive to the child's distress would receive this score.

2 = Minimally characteristic. This rating should be given to caregivers who display infrequent or weak sensitivity/responsivity. While the caregiver is sometimes sensitive, the balance is clearly in the direction of insensitivity.

3 = Moderately characteristic. This rating should be given to caregivers who are predominantly sensitive/responsive. The caregiver responds promptly to child distress, demands and signals quickly and appropriately on most occasions, but not this way on others, or may respond quickly, but not fully, or fully, but only after some delay on an occasion or two. This caregiver's limited sensitivity on occasion does not outweigh his/her sensitivity. The child experiences a predominantly sensitive caregiver.

4 = Highly characteristic. This rating should be given to caregivers who are exceptionally sensitive and responsive to distress. The caregiver responds quickly and appropriately to the child's distress. If the child is upset, the caregiver takes time to soothe and calm the child. There may be proportionally few instances of ignoring and/or minimally responding to the distress, but overall most responses are prompt, appropriate, and effective.

9 = No opportunity to observe. No instances of child distress are observed.

Sensitivity/Responsiveness to Nondistress (adapted from Fish, 1990)

This scale focuses on how the caregiver observes and responds to the child's social gestures, expressions, and signals. The key defining characteristic of sensitive interaction is that it is child centered. The sensitive caregiver is tuned to the child and manifests awareness of the child's needs, moods, interests, and capabilities, and allows this awareness to guide his/her interaction. In toddlers this also includes sensitivity to the child's own agenda, his needs for autonomy, independence, and mastery, and his individual self-regulatory abilities (and deficiencies). The sensitive toddler caregiver structures the child's physical and social environment so that the child has legitimate, interesting options for play, so the child's preferences can be honored within reason, and so that the child can remain effectively engaged in playful or goal-directed activity. The sensitive caregiver also offers frequent praise and encouragement, withholds criticism, and provides the right mix of support and independence so that the child can experience master, success, pride, and develop effective self-regulation skills.

If the child initiates social gestures verbally or nonverbally (e.g., looking at the caregiver, reaching toward the caregiver, waving, clapping hands, handing objects, directing speech toward caregiver), or makes demands, desires, or requests known (stretching arms to be picked up, reaching for toys the caregiver is holding, asking for things or attempting to verbally request), the sensitive caregiver responds appropriately, based on the child's cues.

If the child appears disengaged, the sensitive caregiver takes time to reengage the child in a manner that demonstrates awareness of and sensitivity to the child's mood and preferences for play style and content. When the child is bored or frustrated, the caregiver offers toys, activities, or other engaging opportunities; or helps the child decide what to get involved with or help the child make the transition to the new activity. When the child is interested and involved with toys, the sensitive caregiver allows him/her time to independently explore them.

As much as possible the toddler is given choices for play. This includes choice of toy and how to play with them, or choices among caregiver structured activities, among roles in a game and so forth. How and what they play is geared to whether or not the child seems to be enjoying the activity. The caregiver either does not persist with an activity or toy which the child is obviously not enjoying, or tries to engage the child's interest by appealing to the child. For example, if a child doesn't want to sing with the group during circle time, the caregiver might ask the child to choose a song, or if he/she has a favorite song for the group to sing. The difference between toddlers and infants is that older children are both more active and reactive in their likes and dislikes. Unlike with infants, it is not always best for the toddlers to "have his own way." The sensitive caregiver, however, permits the child as much choice, control, and autonomy as possible even while enforcing necessary rules, regulations, and constraints.

A sensitive caregiver provides stimulation that is situationally appropriate. He/she acknowledges the child's interest, efforts, affect, and accomplishments. Sensitive caregivers need not spend all the time engaged with the child, but the difference between them and the detached caregiver is that the sensitive caregiver seems to be actively taking an interest in the child's activities, as evidenced by comments, embellishments, or redirection when the child loses interest, achieves success or does something new and interesting. It is at these times that the difference between the sensitive caregiver and the detached, understimulating caregiver is most easily seen; the detached caregiver does not respond, responds in a listless manner, or responds with developmentally inappropriate comments and behavior. The insensitive caregiver could also be overstimulating/intrusive and might continue in his/her attempts to engage the child even when the child is providing clues that he/she is seeking to end the interaction.

A sensitive interaction is well timed and paced to the child's responses, a function of its child-centered nature. Such an interaction appears to be "in sync." The caregiver paces activities to keep the child engaged and interested, but also allows him/her to disengage if interest is lost and generally to shape the nature of the involvement. Sensitivity involves judging what is a pleasurable level of arousal for the child and helping the child to regulate arousal and affect. When the child loses interest, the sensitive caregiver offers a new activity and observes the child's reaction, or stops interacting entirely. In this way the sensitive caregiver can be distinguished from both an intrusive and a detached caregiver.

In the preschool years, the primary developmental issues no longer center on establishing a close relationship with a primary caregiver, rather they now center on establishing autonomy and control within that relationship, in concert with the self-regulation and compliance demanded by adults. At the same time as demanding independence, the toddler child struggles with it, often needing to be dependent as in infancy. The sensitive caregiver is flexible in supporting and responding to these aspects of development. When the child must change activities (e.g., it's time to eat lunch, to go outside, to clean up), the sensitive caregiver gives ample advance warning. She or he couches requests in positive terms, uses please and thank you, provides explanations, and avoids commands where possible. Sensitive caregivers more often use terms like "let's do x" or "you (or we) need to do x now" or "I need you to do x now." The sensitive caregiver times requests to coincide with changes in the child's interest or activities, avoiding interrupting or trying to make transitions away from intense involvement. The sensitive caregiver takes into account the child's personal style and ability to self-regulate (does this child dawdle more than others? does this child have difficulty with transitions? is this child distractible?) in the timing and content of requests. The sensitive caregiver recognizes and encourages the child's independence, but does not demand it. At the same time she or he permits the child to be dependent when the child needs it.

During the preschool years sensitivity to nondistress can also be inferred on the basis of how the caregiver manages disciplinary encounters. The sensitive caregiver is neither over controlling or detached, but rather is attentive to child behaviors that need sanctioning and responds in a way whereby the sanction fits the misdeed. Thus, behaviors that pose dangers to the child and others are responded to quickly and clearly and perhaps firmly (though not severely) in order to let the child know clearly that such actions are intolerable. Behaviors, in contrast, that represent rule violations (e.g., going to a part of the house that is off limits for cleanliness reasons) or discourtesies (e.g., taking another's toys) should be responded to less severely and perhaps with somewhat less immediacy (due to the absence of physical danger). Sensitive discipline frequently involves indication by the caregiver that he/she is aware of what motivates the child (e.g., "I know you wanted that toy;" "it's difficult to stay away from such pretty things, isn't it?") and the offering of an explanation or rationale for why the discipline is taking place (e.g., "that's dangerous, so I can't let you play with it;" "Sarah had the toy first, so she gets to keep it for now"), and/or a substituting toy or activity (e.g., "you may not pull out the colors now, but I will read you a book"). To be noted, however, is that excessive explanations and rationales can reflect insensitive-instrusive caregiving rather than sensitive caregiving. Long-winded speeches and lectures often reflect the caregiver's lack of awareness of the child's developmental level. Prohibitions that are at the whim of the caregiver rather than in keeping with appropriate guidelines for toddlers are not "child centered." Similarly, prohibitions that the child is incapable of understanding are manifestations of insensitive discipline. In sum, sensitive discipline is discipline that varies in accordance with the nature of the misdeed and suggests that the caregiver does not hold inappropriate expectations of the child in question.

Markers of sensitivity include (a) acknowledging the child's affect; (b) caregiver conversation that is responsive to the content of the child's talk and or activity; (c) facilitating, but not over controlling the child's play with objects or his/her motor activity; (d) evidence of good timing paced to the child's interest, activities, and arousal level; (e) changing the pace when the child appears understimulated, overexcited, or tired; (f) picking up on the child's interest in toys or games; (g) shared positive affect; (h) encouragement and praise of the child's efforts; (i) providing an appropriate level of stimulation and appropriate range and variety of activities; (j) timely discipline that matches the nature of the violation under consideration and the child's ability to understand and benefit from whatever reprimand is offered; and (k) general flexibility in handling compliance and autonomy issues, including not over-reacting to noncompliance and supporting autonomy while permitting dependence.

Thus, the sensitive caregiver demonstrates the ability to adapt her/his behavior to the child's mood and level of development. The caregiver neither over- nor underestimates. The caregiver knows when it is time to increase or reduce the amount of stimulation the child is experiencing. For example, the caregiver discontinues an activity that is beyond the child's capacity for response or introduces a new activity when the child appears bored.

Ratings on this scale should be based on both quality and quantity of caregiver behavior.

1 = Not at all characteristic. There are no signs of caregiver sensitivity. The caregiver may be either predominantly intrusive or detached. The caregiver rarely responds appropriately to the child's cues, and does not manifest an awareness of the child's needs. Interactions, if they occur at all, are characteristically ill timed or inappropriate.

2 = Minimally characteristic. This rating should be given to caregivers who display infrequent or weak sensitivity/responsivity. While the caregiver is sometimes sensitive the balance is clearly in the direction of insensitivity.

3 = Moderately characteristic. This rating should be given to caregivers who are predominantly sensitive/responsive. The caregiver demonstrates sensitivity in many interactions but not in others, or may show some insensitivity while being predominantly sensitive (e.g., available and responsive to child's needs but some responses are more adult-driven than child driven).

4 = Highly characteristic. This rating should be given to caregivers who are exceptionally sensitive and responsive to nondistress. Instances of insensitivity are rare and never striking. Interactions are characteristically well timed and appropriate.

Intrusiveness/Over Control (adapted from Fish, 1990)

Intrusive and overcontrolling interaction is definitely adult centered rather than child centered. Prototypically, intrusive/overcontrolling caregivers impose their agenda on the child despite signals that a different activity, level, or pace of interaction is needed. High arousal or a rapid pace are not, by themselves, indicative of intrusive overstimulation--if the child responds positively with sustained interest and does not engage in defensive behaviors. Intrusiveness and overcontrol are apparent when the caregiver does not allow the child a "turn" or an opportunity to respond at his/her pace. Some intrusive/overcontrolling caregivers overstructure toddlers' play; they insist on their own agenda or play theme; they interrupt to redirect play; or they insist on particular uses for toys or props (e.g., "it's an apron not a hat"; an oven cannot be a space shuttle), when such control is not necessary for the child's safety or respect for others or their belongings. These caregivers appear unable to relinquish control of the interaction in order to facilitate the child's exploration or regulation of the activity. Another example of controlling, intrusive behavior is displayed by caregivers overwhelming the child with a rapid succession of toys or suggestions, not allowing him/her time to react to one before another occurs. Extreme intrusiveness can be seen as overcontrol to a point where the child's autonomy is at stake. It should be kept in mind that a caregiver can be involved in play with the child without being highly intrusive, if the caregiver follows the child's interest, pace, and signals.

Intrusive, over control is often observed with toddlers during disciplinary encounters. The intrusive-overcontrolling caregiver appears unresponsive to the whys and wherefore of a child's behavior that elicits discipline, instead imposing a system of rigid values and responses that risks obliterating the individuality of the child. Moreover, this kind of caregiving seems more driven by the caregiver's own moods and inflexible attitudes than by the developmental needs of the child. Thus, little distinction may be made in whether the caregiver is disciplining the child for engaging in truly dangerous behavior versus engaging in simply inappropriate or impolite behavior. In such instances, the caregiver does not modify the severity of her discipline in accordance with the seriousness of the child's behavior and is likely to show little interest or concern for the child's feelings or goals. Punishments by highly controlling and intrusive caregivers are likely to not vary as a function of the severity of the misdemeanor and may reflect inappropriate expectations of what the child can be expected to do (e.g., a 15-minute vs. 3-minute time out when a 2-year old takes a toy from another child). It should be noted, too, that another way a caregiver can be instrusive and overcontrolling with regard to discipline is by over doing what would otherwise be judged appropriate caregiver behavior; for example, by going on endlessly explaining to a child why he/she should not do something or excessively drawing a child's attention to the consequences of his/her actions.

Specific behaviors characterizing intrusive/overcontrolling interactions include (a) failing to modulate behavior that the child turns from, defends against, or expresses negative affect to; (b) offering a continuous barrage of stimulation, food, or toys; (c) not allowing the child to influence the pace or focus of play, interaction, or feeding; (d) taking away objects or food while the child still appears interested; (e) insisting that the child do something (play, eat, interact) in which he/she is not interested; (f) not allowing the child to make choices, and (g) by excessively or abruptly disciplining the child.

Caregiver actions which are clearly in the child's best interests, such as removing a child from danger, administering medicine, intervening in escalating or physical conflict, or putting an obviously tired child to bed, are not included in considerations of intrusiveness.

Ratings of intrusiveness must be evaluated from the perspective of the child.

1 = Not at all characteristic. This rating should be given to caregivers who display no signs of intrusive or overcontrolling behavior.

2 = Minimally characteristic. This rating should be given to caregivers who display minimal intrusiveness. There is some evidence of intrusiveness, but it is not typical. The caregiver may initiate interactions with and offer suggestions to the child which occasionally are not welcome or ill timed.

3 = Moderately characteristic. This rating should be given to caregivers who are often intrusive/overcontrolling. Caregiver intrusiveness occurs in some interactions at a fairly high level, but are often totally absent; or moderately instrusive/controlling behavior is evident more often; or for caregivers who rarely interact, a substantial proportion of their interactions are intrusive.

4 = Highly characteristic. This caregiver's interactions with the child are consistently and typically intrusive. During their interaction, the caregiver controls the interaction, allowing the child little self-direction in his/her activities. During the time that they are interacting, the caregiver allows the child little autonomy, and essentially negates the child's experience.

Detachment/Disengagement (adapted from Fish, 1990 and Arnett)

The detached/disengaged caregiver appears emotionally uninvolved or disengaged, and unaware of the child's needs for appropriate interaction to facilitate involvement with objects or people. This caregiver does not react contingently to the child's speech, play or other actions, and does not provide the interpersonal support or "scaffolding" which would enable the child to expand his behavioral repertoire and activities. Thus, there is little joining in the child's play, participating in conversation, or even awareness of what the child is doing. Detached caregivers "miss" the child's bids to them, signals of frustration or difficulty in goal-directed behavior, and initiations or escalations of peer conflict. Moreover, when caregivers do get around to interacting with the child, their timing is often out of synchrony with the child's affect and responses (although not with the overwhelming barrage of stimulation that intrusive caregivers present). Simply allowing the child to play by him/herself is not necessarily a sure sign of detachment; this can be appropriate at times, such as when the child is playing happily or contentedly and the caregiver checks in with the child visually. This is especially true of toddlers who must be given time, space, and independence to explore the object and social worlds. The detached/disengaged caregiver is passive, and lacks the emotional involvement that characterizes a sensitive caregiver. He/she appears uninterested in the child, the child's activities, and the child's successes, failures, and struggles.

During the preschool years, detached caregiving is often evident in the disciplinary encounters that do NOT take place or in the insufficiency of those that do occur. Detached/undercontrolling caregivers often fail to act when potentially dangerous situations arise or when peer conflicts get out of hand or when the child is doing something that he/she has been told he/she should not be doing. At the extreme, detached caregivers simply fail to monitor the appropriateness of child behavior so that they can step in when some kind of discipline or adult control is called for. It may also be the case that detached caregivers simply fail to follow through with their stated intents (e.g., tell a child he will get a time out if he does a particular action again, but then failing to give the time out when the action re-occurs) or do so in a too-limited or inconsistent manner (e.g., instead of giving the time out, repeat the warning; start to give the time out, but then get distracted).

A caregiver receiving a high rating for detachment/disengagement is considered to be insensitive. A low rating for detachment can signal either sensitivity or intrusiveness.

Detachment can be marked by (a) the child being out of sight of the caregiver for extended periods without the caregiver checking in to see what the child is up to; (b) rarely being involved with the child in play, learning or conversation; (c) failing to respond to the child's approaches, vocalizations, smiles, or other social bids; (d) evident lack of awareness of the child's engagement in inappropriate behavior; (e) failing to respond to behavior and situations that call for adult regulation of child experience or responding half-heartedly and inconsistently, (f) permitting long stretches of unoccupied time or wandering without directing the child to an activity; (g) ignoring the child's difficulties with the physical environment, especially where such difficulties are emotionally stressful for the child, e.g., problems with handling a spoon, problems getting dressed, problems getting blocks to stack, etc. (The sensitive caregiver permits the child ample opportunity to try to solve the problem by herself, stepping in when necessary to prevent too much frustration or disappointment; the intrusive caregiver steps in too soon, never allowing the child the autonomy to try to solve the problem himself; the detached caregiver doesn't step in at all, or only when the child is so distressed that it cannot be ignored); and (h) says, or conveys nonverbally, "don't bother me; stay out of my way; leave me alone." Some detached caregivers place an overemphasis on the physical setting and other adults (e.g., visiting with other caregivers, filling out forms, straightening the room) instead of attending to the child.

This scale contains both qualitative and quantitative components. A caregiver who interacts consistently with the child but does so in a perfunctory or indifferent manner with little or no emotional involvement would be rated high on detachment. Exactly how high the rating should be will depend on the extent of child behavior that merits efforts by the caregiver to control and regulate it but which go uncontrolled and unregulated by caregiver.

1 = Not at all characteristic. This rating should be given to caregivers who display no signs of detachment or underinvolvement. When interacting with the child, the caregiver is clearly emotionally involved. And when not interacting with the child these caregivers are aware of what the child is doing. These caregivers can be sensitive or intrusive.

2 = Minimally characteristic. This rating should be given to caregivers who display minimal detachment while the caregiver is sometimes noninvolved, he/she is clearly more involved than not.

3 = Moderately characteristic. This rating should be given to caregivers who are mostly detached. The caregiver is unaware of what the child is doing and where s/he is at fairly often.

4 = Highly characteristic. The child spends virtually all of his/her time without caregiver attention, or at best only visual attention. In the minimal instances of involvement, the caregiver's behaviors are simple, mechanical, stereotyped, repetitive, and perfunctory. The caregiver is

clearly not emotionally involved with the child, and appears to be "just going through the motions."

Stimulation of Cognitive Development

This scale measures the degree to which the caregiver tries to foster the child's cognitive and mental development. A stimulating caregiver may take advantage of even simple activities (eating, dressing, potty) to stimulate development, and will consistently engage in a variety of activities that can facilitate learning. The caregiver will make deliberate attempts to encourage the child's development, achievement, and learning.

Behaviors characterizing stimulation include (a) attempting to focus the child on an object or task; (b) focusing the child's attention on the unique attributes and perceptual qualities of objects (i.e., their colors, how they move, what they can be used for); (c) suggesting more sophisticated play activities (e.g., "what if you tried..."); (d) verbally responding to and expanding on the child's verbalizations or vocalizations; and (e) encouraging the child to actively participate in activities. However, caregivers who simply focus or encourage a child should not be given the highest scores. Higher scores should be reserved for those caregivers who (a) describe, label, or ask questions about toys or objects, or demonstrate how they work; (b) stimulate the child's speaking and expand on their verbalizations; (c) read or recite to the child; (d) encourage and reinforce the child's attempts at mastery, or challenge the child to try something new; (e) present activities in an organized sequence of steps; (f) teach the child or give him/her an opportunity to experiment with materials that illustrate or teach concepts; (g) ask questions that require problem solving; (h) label and interpret the child's experiences, (e.g. "You think that's funny"); and so on.

Activities involving strictly physical stimulation such as rough and tumble play, bouncing, and tickling are not considered as stimulating development in terms of this rating. Nor do those activities that are only social (hugging or smiling) or caretaking (soothing) qualify as stimulation of development in terms of this rating scale.

The focus of this scale is on the amount and quality of activities that may ultimately enhance perceptual, cognitive, linguistic, and physical development. Simply placing objects in front of a child or handing him/her toys is not to be considered stimulating. Stimulation must involve effortful interaction with the child in the contexts described above.

1 = Not at all characteristic. The caregiver makes almost no attempts to teach the child anything or provide any stimulation. He/she may provide routine care but does not use it as an opportunity for learning. The caregiver may ignore the child's activities or interact perfunctorily, providing no stimulation.

2 = Minimally characteristic. This rating should be given to caregivers who provide infrequent or weak stimulation. The caregiver's conscious and purposeful attempts to engage in development-fostering experiences are limited. He/she may label or demonstrate materials, but does so perfunctorily and/or with minimal elaboration.

3 = Moderately characteristic. This rating should be given to caregivers who provide adequate stimulation but could reasonably be expected to provide more and higher-quality stimulation. The caregiver does make some effort to provide stimulation, but does not consistently take advantage of opportunities to do so. Stimulation is not the main agenda. The caregiver may find some new ways to engage the child with toys, for example, but these ways are limited in number. Actions are likely to be simply repeated rather than thoughtfully varied. Caregivers who provide a rich linguistic environment but do not demonstrate the potential of toys or objects would receive this rating.

4 = Very characteristic. This rating should be given to the caregiver who is consistently stimulating and takes advantage of many activities as opportunities for stimulation. The caregiver provides frequent stimulation through "lessons," explanations, activities, or toys. Teaching or fostering development is a primary intent of the caregiver's frequent interactions with the child. The

caregiver thoughtfully varies and elaborates on these activities, providing numerous opportunities which are exceptionally advantageous to the child. He/she provides rich stimulation in terms of language, and embellishment of the potential of the physical world.

Positive Regard for the Child

This scale rates the caregiver's positive feelings toward the child, expressed during interaction with him/her. Positive feelings are shown by (a) speaking in a warm tone of voice; (b) hugging or other expressions of physical affection; (c) smiling; (d) laughing with the child; (e) enthusiasm about the child; (f) praising the child; and (g) general enjoyment of the child. Positive regard is evident when the caregiver listens, watches attentively, looks into the child's face when talking to him/her, has affectionate physical contact, and is playful.

Ratings on this scale are based on both quality and quantity of positive regard.

1 = Not at all characteristic. This rating should be given to caregivers who display no positive regard. This rating can also be used for positive expressions (laughing, smiling) that appear to be inappropriate to the situation or an inaccurate reflection of the caregiver's feelings. The caregiver may be expressionless or flat, or negative.

2 = Minimally characteristic. This rating should be given to caregivers who display infrequent or weak signals of positive regard. The intensity or frequency of behavioral indicators are very low.

3 = Moderately characteristic. This rating should be given to caregivers who typically display positive regard. More frequent and intense positive affect is shown than in the 2 rating, but the caregiver is not as consistently positive as those scored as a 4.

4 = Very characteristic. This rating should be given to caregivers who are exceptionally positive, in terms of facial and vocal expressiveness, and behavior. Affect is positive, spontaneous, and frequent. The caregiver shows a range of expressions and behaviors which are all clearly positive. He/she clearly "delights" in the child.

Negative Regard for the Child

This scale rates the caregiver's negative regard for the child. Both frequency and intensity of negative affect toward the child are considered. Some markers of negative regard include (a) disapproval; (b) tense body; (c) negative voice when correcting; (d) abruptness; (e) tense facial muscles and strained expression; (f) harshness; (g) threatening the child or punishing without explanation; and (h) roughness when providing basic care and handling. In toddlers especially, autonomy and noncompliance bids may elicit anger or rough handling. These are indicative of negative regard for the child. However, in toddlers not all angry expression by the caregiver is negative regard. For example, if the child bites or pulls another child's hair, and the caregiver says "That makes me angry when I see you hurting other children" with an angry voice, that is an appropriate affective message and does not indicate negative regard for the child. Hence this scale gets at anger that is inappropriate in cause or in intensity. If the caregiver blows up when a toddler spills her milk by accident, or abruptly jerks a child who has pulled another child's hair, that is inappropriate anger. Remember, you are getting at negative regard for the child with this scale, and not negative affect alone.

Ratings on this scale are composed of both qualitative and quantitative evaluations. The amount and intensity of negative regard exhibited is evaluated in relation to the duration of the observation period.

1 = Not at all characteristic. This rating should be given to caregivers who do not display negative regard for the child either in words or in expressions. No evidence of anger, distrust, frustration, impatience, disgust, general dislike, or other indicators of negative regard is observed in the caregiver's face or voice. The caregiver may be expressionless or flat, or positive.

2 = Minimally characteristic. This rating should be given to caregivers who display minimal negative regard. There is some evidence of low-intensity negative regard.

3 = Moderately characteristic. This rating should be given to caregivers who regularly display negative regard. Multiple instances of low-intensity negative regard or some evidence of more-intense negative regard is observed.

4 = Highly characteristic. This rating should be given to caregivers who are extremely negative. Feelings of negative regard are expressed strongly and repeatedly, or persistent moderate levels of negative regard are expressed. The overriding affect influencing the caregiver-child interactions is negative.

Flatness of Affect

This scale measures how animated the caregiver is with the focal child and others in the room. Flat affect may reflect boredom, depression, fatigue, or distraction. Flatness is exhibited by blank, impassive facial expression, and flat tone in vocal expression. It is marked by a lack of animation. If the caregiver is watching the child with interest (eyes "bright"), it is a sign that the caregiver's affect is not flat. This scale assesses the caregiver's overall demeanor, not just animation with the target child.

1 = Not at all characteristic. This rating should be given to caregivers who exhibit almost no flatness. The caregiver's demeanor and behavior are consistently animated.

2 = Minimally characteristic. This rating should be given to caregivers who exhibit some flatness. The caregiver is usually animated, but there are occasions when facial expression and/or voice is blank and impassive.

3 = Moderately characteristic. This rating should be given to caregivers who are mostly flat. Some periods of animation alternate with more clear periods of flatness than observed for a score of 2. Flat affect predominates.

4 = Highly characteristic. This rating should be given to caregivers who are consistently flat. There is consistent absence of animation.

b. Child ratings

Positive Mood

This scale assesses the extent to which the child is satisfied, content, and pleased with the situation overall. Measures of child positive affect include smiles, laughter, and positive tone of voice, as well as enthusiasm expressed with arms, legs, and body tone. Lack of positive affect may be manifested by a neutrality or negative mood.

Ratings on this scale should be based on quality and quantity of behavior. Attempt to balance both the intensity of the child's positive affect and the relative amount of time positive behavior is shown. A rating of 1 should be given to those children who exhibit no positive affect and give no evidence of feeling good. A rating of 2 should be given to children who are content during the observation period and show perhaps one or two fleeting smiles or laughs. When a child displays more positive affect than just contentment via smiles, laughs, and/or really enthusiastic playfulness more than just a few fleeting times, or does so even once or twice for a more extensive period, a score of 3 is appropriate. When there are lots of fleeting smiles or laughs or the like or several extensive truly happy, enthusiastic periods, a score of 4 is called for.

1 = Not at all characteristic. This rating should be given to children who display no signs of positive mood. The child provides no real indication of being happy, content, or even in a pleasant state.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak positive affect. The child may show brief instances of strong or moderate strong positive affect, or the child may be characteristically pleasant, content or satisfied throughout the observation period, without exhibiting any strong indicators of positive mood.

3 = Moderately characteristic. This rating should be given to children who frequently display positive affect. The child exhibits several instances of strong positive affect (expresses enthusiasm, playfulness, smiling, and laughter) and is often pleasant.

4 = Highly characteristic. This rating should be given to children who are exceptionally positive, in terms of physical and vocal expressiveness. The child displays multiple instances of strong positive affect and is characteristically "pleasant" for most of the remainder of the observation period. The child should truly "radiate" or "sparkle." For this rating, a child can have no episodes of strong distress.

Negative Mood

This scale assesses the extent to which the child cries, fusses, frowns, yells, screams, or tenses body while crying, or otherwise expresses his/her discontentment anger or hostility. Lack of negative affect may be manifested as either strong positive affect or contentment.

Ratings on this scale should be based on both qualitative and quantitative assessments.

1 = Not at all characteristic. This rating should be given to children who display no negative affect. There are no

signs of strong (intense crying, body stiffening) or weak (fussing) negative affect from the child during the observation period. A "1" may also be scored if a single mild fret occurs.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak negative affect. The child displays brief instances of mild negative affect.

3 = Moderately characteristic. This rating should be given to children who display strong and/or more frequent negative affect. The child displays one or two instances of strong negative affect or is moderately discontented (fussy, whining) throughout much of the observation period.

4 = Highly characteristic. This rating should be given to children who display high levels of negative affect. The child displays several instances of strong negative affect during the observation period and appears to be rarely contented.

Activity Level

This scale assesses how motorically active the child is during the observation. The rating should take into account these aspects of motor activity: speed (moving fast, whether walking, crawling, or squirming); frequency (spending a lot of time in high energy activities); intensity (how energetic the activity); involvement (tendency to engage in high-energy games and gross motor activities over small motor activities); and a negative reaction to enforced nonactivity (reacting with restlessness).

1 = Not at all active. This rating should be given to children who are noticeably low key, passive, inactive, lethargic. The child typically stays in one place.

2 = Minimally active. This rating should be given to children who are minimally active. The child exhibits some activity.

3 = Moderately active. This rating should be given to those children who are predominantly active. High-intensity activity occurs a few times or the child is less intensely active for most of the observation session.

4 = Highly active. This rating should be given to children who are overwhelmingly active. The child is constantly moving some body part; something is moving at all times. The child prefers active games and activities to nonactive ones.

Sociability with Peers

This scale assesses the degree to which the child actively and positively/neutrally (but not negatively) participates in his/her social world with peers. Behaviors which can be considered to indicate sociability include talking to, smiling at, waving to, sharing toys with, crawling or walking to, as well as touching and playing with peers. These behaviors may be initiated by the child, or be responses to peers' signals or initiations.

Initiative and responsive behaviors must be construed to have a positive social interactive intent.

Ratings on this scale should be based on both quality and quantity of behaviors. The fact that a child may have negative encounters with a peer should not be considered in making this rating. Therefore, do not lower the score a child would get on positive/neutral sociability with a peer to take into account any negative interactions the child may have had with peers.

1 = Not at all characteristic. This rating should be given to children who display almost no sociability. There are no social initiations by the child or responsiveness to peers' overtures. The child seems oblivious to or disinterested in peers.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak social behavior with peers. Social initiations or responses by the child occur, but they are very infrequent or ambiguous. The child is usually engaged in his/her own activity and seems to generally be uninterested in the other children. Peers must typically be persistent to gain the child's social interest, which tends to be brief and of low intensity (e.g. a look).

3 = Moderately characteristic. This rating should be given to children who display frequent social behavior with their peers. The child initiates and/or responds, but the intensity and frequency of the child's behavior is less than a 4.

4 = Highly characteristic. This rating should be given to children who are very sociable. The child initiates and/or responds very frequently, using a variety of behaviors. There are multiple instances of the child directing clear, positive signals to other children and/or responding to others' initiations.

9 = No opportunity to observe. No occasions for child sociability were possible.

Sustained Attention with Objects

This scale assesses children's sustained involvement with the world of objects. To be included as involvement with objects is attention paid to books being read by a caregiver or to television only when there is explicit motor or verbal evidence that the child is engaged by these objects (e.g., vocalizing, pointing, clapping hands; thus more than passive attention is required.) The child's attention does not jump from one thing to another quickly. The child spends more than a minimal amount of time focusing on the object he/she is in contact with. When focusing on an object the child really "focuses in." The uninvolved child may appear apathetic, bored, distracted, distressed, or aimless.

The focus of this scale is primarily quantitative. Ratings are based primarily on the duration of interactions with objects, and the overall amount of time spent in these interactions.

1 = Not characteristic. This rating should be given to children who display no sustained attention. The child moves from one thing to another in a nonsystematic way, without seeming to focus on what the objects have to offer.

2 = Minimally characteristic. This rating should be given to children who can sustain attention for only brief periods or for only a limited proportion of the observation period.

3 = Moderately characteristic. This rating should be given to the child who spends more than the minimal amount of time involved in interactions with things. There are a few extended bouts of focussed attention or brief bouts occur often.

4 = Highly characteristic. This rating should be given to the child who is clearly involved, interested, and focused most of the time. When the child is playing with objects he/she is interested in playing with them and is engaged for extended periods of time. To receive this high a score a child cannot have very frequent short bouts of attention (that might seem to cumulatively add up to lots of focussed

attention), but must display truly extended bouts of sustained attention.

Child's Engagement with Caregiver (adapted from Booth, 1991)

This scale assesses the extent to which the child is socially connected to the caregiver. Behaviors indicative of engagement include (a) positive responding to the caregiver's initiation of a play activity (attending to the caregiver's suggestions or demonstrations of an activity, and following her lead by adopting that activity of incorporating an offered object into ongoing play); (b) initiating play that includes the caregiver (by offering/showing an object, requesting help, etc.); (c) positioning/orienting body toward the caregiver, and (d) sustained attention during interaction or play with the caregiver. Behaviors indicative of disengagement include (a) active rejection of caregiver's play overtures (by pushing offered objects away, ignoring the caregiver); (b) engaging in self-occupied play that excludes the caregiver; (c) positioning/orienting body away from the caregiver.
Ratings on this scale should be based on both quality and quantity of behavior.

1 = Not at all characteristic. This rating should be given to children who display no engagement with the caregiver. Children given this rating seem clearly disconnected and disengaged. They actively reject or ignore the caregiver's

efforts to engage them and/or initiate no such efforts on their own.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak engagement. These children are somewhat responsive to caregiver, but not in a sustained way. Brief periods of engagement may occur. Play appears self-occupied -- typically it excludes the caregiver although active rejection also may be present.

3 = Moderately characteristic. This rating should be given to children who are more engaged with the caregiver than not. The child initiates and/or responds but the intensity and/or frequency of the child's behavior is less than a 4.

4 = Highly characteristic. This rating should be given to children who are very engaged with the caregiver. The child has a high frequency of initiations that include the caregiver and/or positive responses to the caregiver's initiations. Sustained play with the caregiver is observed.

6. Post Visit Interview And Ratings of the Caregiving Environment

At the end of the visit, interview one caregiver to determine whether your observations were "typical." If there is more than one caregiver, interview the one who interacted most with the child. Do not change the answers the caregiver gives you. He/she may contradict herself by saying "yes" to question 1 and then "yes" to several items on question 2. Do not change her answers to make them consistent.

At the end of each day's visit, complete the End of Visit Ratings of overall quality of child care, etc. Base these ratings on your observations during the entire day's visit.

Question 7.

Record your best assessment of the amount of time CHILD was outdoors during your visit.

Question 8.

Record your best assessment of the amount of smoking you observed during this visit.

Definitions:

0 = None

1 = A little - Observed only one cigarette smoked in outdoor setting.

2 = Some - Observed one cigarette smoked near child's face (within 3 feet) or several cigarettes smoked at a distance (>3 feet from face).

3 = Moderate - More than 1 cigarette smoked near Child/s face.

4 = A lot - Air is smoky during most of the visit.

Overall positive relationship between caregiver and child (love/attachment) Complete this rating for the caregivers for whom you made Qualitative Ratings.

Caregiver is positive, affectionate to child -- to target child in particular, not just any child -- and child uses caregiver as source of comfort, someone with whom to share experiences.

There is a loving relationship between the two. "Love" is difficult to observe; it must be inferred on the basis of everything that occurs over the course of the observation, including mutual attentiveness, closeness of physical contact, tenderness, responsiveness, and care. The frequency of mutual positive regard, the caregiver's patience and sensitivity, and the intensity and tenderness with which all of these are expressed are all involved. The relationship may be expressed in exuberant actions such as snuggling and cooing or gentle ones such as quiet reassurance or warm holding and whispering. It is not pride, as in showing off the child to others, or the habitual smile used as a defense against apathy; rather, it is an spontaneous expression of strong (mutual) attachment.

1 = no evidence of a special loving relationship; caregiver never singles out the target child for special attention or affection; child indicates no preference for caregiver

2 = hints that a positive relationship may be developing, some evidence of positive feeling, but minimal

3 = definitely is a relationship but it is not strongly or uniformly positive; it may be ambivalent

4 = clear evidence of a strong loving relationship between caregiver and child

9 = inadequate opportunity to observe/rate -- impossible to judge the nature of the relationship between the caregiver and child because they interacted so little (because of extenuating circumstances, not neglect)

Child-centeredness of care

1 = care is inadequate or barely adequate; what matters is the convenience of the staff. No adult is devoting her full attention to making the lives of the children better.

2 = care is adult centered: infants may receive adequate care, be responded to promptly, but this is largely in the service of adult goals. Care is never hostile, rejecting, or inappropriate, but it is also not marked by any special gentleness, respect, appreciation, interest in particular children, etc.

3 = care is somewhat/sometimes child centered; sometimes or some children get good care.

4 = care is consistently child centered. When adults talk to each other it is about the children. Children are talked about with pride, wonder, appreciation, and concern. When adults care for children, it is with the goal of maintaining or improving their comfort, contentment, interest, etc., rather than with making the adult's experience more interesting. There is marked gentleness in handling, marked

pride and affection in tone of voice, marked concern with children's well-being, and clear, concerted efforts to provide children with nurturing, stimulating experiences. This scale refers to the caregivers' approach to all children, in general, not just to the target child. All the children get good care.

Coder's overall impression of child care

This is an overall global rating of the child care observed during the visit, ranging from terrible to excellent. It should be based on the quality of the child's experience, the caregiving provided, and the general ambiance of the setting (including what is happening to other children during your visit).

Maladaptive Behavior Checklist

Code yes or no to each item indicating whether you saw any of the caregiver or child behaviors as described at any time during your visit. Other refers to any other adult present during the visit. Note that only smoking behaviors are recorded in this column. Unless the item specifies "target child," these items for the caregiver apply to interaction with the target child or any other child in the setting. Prolonged blank stare = catatonic. Unconsolability = cannot be consoled even though the caregiver tries everything.

How typical was the day

The purpose of these scales is to try to ascertain whether the day was markedly atypical. Use your best judgment to rate how ill at ease each caregiver was. Indicate your impressions of how much the target child tried to interact with you.

H. Profile Observation Procedures

Two instruments are being used to provide a comprehensive assessment of the quality of the child's child-care arrangement. The Assessment Profile for Early Childhood Programs (Abbott-Shim & Sibley, 1987) is used for all center-based arrangements; The Assessment Profile for Family Day Care (Sibley & Abbott-Shim, 1987) is used for all other arrangements, ranging from family day care homes to relative care to care in the child's own home (all settings that also serve as residences). There are a few items on this version of the Profile that will not be completed for arrangements in which the target child or the target child and his/her siblings is/are the only children in care (i.e. all Individualizing items). If the caregiver has any of his/her own children at home at the same time, then code these items. These items are noted on the coding form. In addition, EXCLUDE the entire Profile when assessing child-care arrangements in which the child is cared for at the mother's workplace when this workplace is not a child-care center/home.

Note that this is a room-level assessment of quality. You need to rate these items considering all the children who receive care, not just the target child. Think of these items as measures of the child's child-care environment, not his/her direct caretaking. For example, it may not seem relevant whether the diapering surface is disinfected after each use if the TC is toilet trained. However, if there are infants in the TC's room, then these items need to be rated. If there are no infants, then these items get rated as "yes."

If you do not observe what you need to observe in order to complete an item (no diapering, no cooking, etc.) ASK the caregiver about the item and code her response in the "R" column. Other items require that you inspect documents, in which case your rating is made in the "D" column.

1. Overview of the Instruments

The Assessment Profile for Early Childhood Programs is an observational measure that provides a comprehensive, systematic assessment of center quality. The Profile is organized in a series of levels of increasing specificity. The first level is broad and includes four program Components: Administration, Preschool, Infant, and School-Age. The 24-month assessment uses a combination of the Infant + Preschool Components. The next level is more specific and focuses on a number of Dimensions within each Component, e.g., Safety and Health. Each Dimension contains a set of Standards. Standards are general statements that represent values and expectations. Each Standard is supported with specific Criteria. Criteria are concrete, observable procedures, behaviors, and records that exemplify values and expectations.

Observations are recorded for Criteria as either "yes" for observed or "no" for not observed. To obtain the most accurate information, three methods of data collection are used: observation (O) of classrooms, review of documentation (D), and report (R) based on conferences with directors and staff. Observation involves observing for physical characteristics and interactions. Documentation involves a review of a variety of records. Report involves conferences with program staff and teachers. On the data code sheet, the observer has 6 response choices: Yes - O, R, D and no - O, R, D. Only one choice should be recorded per item to indicate simultaneously whether the criteria is a yes or no and how this information was obtained.

The Assessment Profile for Family Day Care is the counterpart to the Assessment Profile for Early Childhood Programs, adapted to suit the circumstances of home-based care. As with the Program Profile, the Profile for Family Day Care is organized in a series of levels of increasing specificity. Each Dimension (e.g., Learning Environment) contains a set of Standards. Standards are general statements that represent values and expectations. For example: "The arrangement of physical space encourages the child's independent exploration". Each Standard is supported with specific Criteria. Criteria are concrete, observable procedures, behaviors, and records that exemplify the values and expectations. For example: "Toys for child use are accessible so that children can reach them." Observations are recorded using dichotomous yes/no ratings, and the three methods of data collection -- Observation, Documentation, and Report -- are used.

2. Reduction of Items

Due to time constraints, it was necessary to reduce the items on the Profile for the NICHD Study of Early Child Care. An initial decision was made to use five Dimensions from the Assessment Profile for Early Childhood Programs: Safety and Health, Learning Environment, Scheduling, Curriculum and Individualizing. Based on data from 115 center-based toddler classrooms, provided by Martha Abbott-Shim, on which complete Profile data had been collected, part-whole correlations were examined for each of these three Dimensions to determine the items with the highest correlations to the total scale score. Items with correlations of .30 or higher were retained and an alpha was run on the final, reduced Dimension. These were: Safety and Health = .68 (7 items), Learning Environment = .79 (11 items), Scheduling = .84 (10 items), Curriculum = .87 (16 items) and Individualizing = .90 (18 items). The Assessment Profile for

Family Day Care was then reduced by cross-walking each item on the reduced version of the Program Profile to a comparable item (or set of items) on the Profile for Family Day Care. No data were available for checking the alphas on these reduced Dimensions. Thus, the reduced Profile for Family Day Care contains 27 items for the Safety and Health dimension, 6 items for the Learning Environment dimension, 3 items for the Scheduling dimension, 13 items for the Curriculum dimension, and 5 items for the Individualizing dimension.

3. Addition of Physical Environment and Adult Needs Subscales - Center Profile

Two dimensions of quality not included in the Profile were added. These are items regarding the physical environment (adapted from Wachs, 1986), and the Adults Needs subscale from the Early Childhood Environment Rating Scale (Harms & Clifford, 1980).

4. Conducting the Profile

Whenever possible, observation is the recommended information source. Ideally, to obtain an accurate representation of the activities and interactions, schedule observations to include a variety of events such as meals, learning activities, outdoor play, naps, and if possible, arrivals and departures of the children. After your ORCE observations, ask the caregiver if there are any other rooms where the child is cared for. Ask to take a quick tour.

Focus your observations on what the target child experiences in his/her classroom. Before ending observations, review all Criteria designated with an "O" for Methods, to be sure that a response has been recorded.

Documentation involves a review of a variety of records that support child care services. The primary purpose for reviewing documentation is to verify specific child care practices. For example, written procedures for emergencies verify that the Provider is prepared to handle emergency situations; a child care handbook verifies that policies have been established and are available in a form that supports communication with parents.

Observations and a review of documents provide concrete evidence of the Provider's practices and procedures. However, there are many activities and procedures that occur and support child care which are not readily observable or represented in tangible documents. Consequently, the Profile also includes criteria which involve the Provider's reports. These Criteria are designated with an "R" under Methods and will involve information the Provider will be able to share to clarify observations, documentation, and procedures.

When items have more than one method designated, observation is the preferred form of data collection. However, on occasion, it is not possible to observe a Criterion. For example, it may not be possible to observe outdoor play because of inclement weather. These instances should be the exception rather than the rule and the information should be gathered through discussion with the Provider. In these instances, record your response under "R".

A yes/no column with O, R, and D response choices indicated is provided to record observations. All criteria are checked O, R, or D under "yes" if positively observed and O, R, or D under "no" if not observed, not observed to occur with consistency, or reported as "does not occur." A choice between "yes" and "no" is required for all Criteria. Some Criteria specify two conditions and both conditions are required to exist to score "Yes". This does not apply to items with "and/or" statements.

We recommend that the Profile observations be completed after the ORCE on the first day's visit, saving any items requiring documentation or reporting to be completed on day 2 during the staff interviews. In general, the child's classroom teacher -- in the case of centers -- will provide the best source for reported and documented data. On occasion, however, some data may need to be obtained from the center director. Do not change ratings made on Day 1 on Day 2, unless you see a violation of a Safety and Health item. In other words, if you have coded a "learning environment" item on day 1, and see something on day 2 that leads you to a different conclusion, do NOT change your code. It is only in cases of safety and health violations that you are allowed to change codes. Put the date of the FIRST visit on the cover sheet.

5. Clarification of Items

a. Assessment profile for early childhood programs (Center Version)

CENTER SAFETY & HEALTH

For all Safety & Health items, if one example of an *unsafe or unhealthy* practice is observed then record the item "NO." One violation is cause for coding "NO." Only one hazard need be present for the item for a "NO" code, unlike the "dominant mode" criterion on the other items. When in doubt, code an item as unsafe or unhealthy. Take into account the actual ages of all of the enrolled children, and rate the environment according to all children who are using it. There is a difference between "enrolled" and "attending" -- you will need to ask the provider to tell you if any children are absent and their ages.

1. Soap and water are necessary. Baby wipes do not adequately cleanse and may not substitute for soap and water.
2. See #1.
3. These items must be used by only one child.
4. If more than one child uses a cot/bed/crib, they must each have their own linens and some labeling must be evident to indicate whose linens are on the cot/bed/crib.

5. See #4.

6. Disinfectant solution (1/4 cup bleach to 1 gallon of water) or other medically approved disinfectants are used. If a bleach and water solution is used, this solution must be mixed daily.

7. Persisting odors are odors that linger more than 15 minutes. Lingering means odors linger/persist more than 15 minutes.

CENTER LEARNING ENVIRONMENT:

Here you will code according to the "dominant mode," and you will have to judge whether the dominant mode of the setting fulfills the item requirements.

1. Physical boundaries are barriers that separate the play space from other classroom areas (such as sleeping, feeding, diapering, etc.) Physical boundaries include walls, shelves, bolsters, etc. A physical boundary is something a child cannot crawl through. A table would not suffice. Walls, shelves, bolsters, etc. would.

2. Conceptually related means items that serve similar functions. Thus, a make-believe corner which encourages fantasy play would count. So would an art corner. So would a shelf that contains manipulative such as puzzles and peg boards.

3. Self-evident

4. Organized implies conceptual groupings, as in item #2, and/or groupings based on the age of the children for whom the toys are appropriate, or some other clear organizational principle. the point here is to look for some system that children can begin to understand. Code "no" if all toys are piled haphazardly onto shelves.

5. A "yes" suggests that you, as a newcomer, could place most toys where they belong based on some labeling system.

6. Self-evident

7. Materials that encourage large muscle exploration are readily approachable for toddlers. There should be three different types (i.e. 3 balls of different sizes would represent 1 type of materials). "Types" means categories of toys, not, for example 3 sizes of balls. This refers to outdoor play materials and experiences only.

8. Social activities outdoors involve at least 2 children. And, they are not accidental or fleeting, as when one child approaches another child simply to exchange a toy and then go separate ways. They can be a directed game of joint patty cake or playing "catch".

9. Close means within arms reach of the children using the equipment. This item refers to outdoor teacher behavior only.

10. Participates means that the teacher is actually interacting with the group. He/she is not talking to other

adults. He/she is not watching other children. And, he/she is doing more than simply watching the group. So, he/she may be reading to, guiding, instructing, playing along with, etc. This refers to outdoor teacher behavior only.

11. Assists means that the teacher is (a) focused on the activities of the children, and (b) instructs, directs, intervenes actively to guide the children's activities. This can include answering questions. His/her involvement is not passive. This refers to outdoor teacher behavior only.

CENTER-SCHEDULING

1. The schedule must be posted; a loose piece of paper or a notebook is insufficient.

2. The plans must be for previous weeks. "File" should be interpreted loosely. Any written evidence of prior plans is fine.

3-8. These items must be included on a written schedule. For the purpose of these items, the schedule does not have to be posted. You will probably need to go over the schedule with the teacher to clarify the nature of the activities.

9-10. These items do not require a written schedule. Record what you actually observe, even if it contradicts a written schedule.

1-3. Must be a minimum of 3 items. these items must be accessible, available during your visit. Do not take the teachers' word that they are available.

4-9. You must see these teaching techniques. If it happens once, code "yes". They do not need to be directed at the target child, necessarily. Indoor and outdoor activities count equally towards these items.

10. These can be independent or group activities. The teacher does not have to be directly instructing the child/ children about the concepts. Self-discovery is okay.

11. A special activity is a pre-planned activity that offers the children a novel experience that would not occur on a routine basis. Special activities mean preplanned activity offering a novel experience.

12. This may be seen during free play periods, or it may be seen in cases where individual children express resistance to a group activity and are allowed to pursue an individual interest.

13. This item captures a balance between teacher-directed and child-directed choices of activities. A "yes" does not require consistent alternating of teacher- and child-chosen activities. A yes does require that children be allowed to choose activities about as often as they are "required" to participate in teacher-led activities.

14. If an activity is too difficult, the child will either get frustrated or will "tune out". If an activity is too simple, the child will either get restless or "tune out". Look to the child for cues on this item.

15. Look for individualized pacing. If a schedule is rigidly enforced for all children, this item will probably get a "no". Include meal times in this assessment.

16. You will need to observe activities that lend themselves to this type of tailoring, as is true of puzzles. Other examples include drawing freely with magic markers for toddlers vs. drawing "in lines" for preschoolers; letting toddlers "get the feel of" playdough while preschoolers make actual shapes; letting toddlers knock down block towers while preschoolers build them.

CENTER-INDIVIDUALIZING:

Again, code for "dominant mode."

GENERAL RULE:

* Items that have to do with assessments, parent conferences, and documentation may be covered in the interview by asking, for example, "Tell me about your procedure for parent conferences. What kinds of things do you discuss with the parents?" Generally speaking, the charts and lists should be a working file that the teacher keeps in the classroom. The calendar of parent conferences should be a written document, and you should be able to see

the record of 2 past or 2 future assessments (item 14). Parent conferences are one-on-one, not in a group meeting, like the PTA. If item 1 is "NO," then items 2, 3 and 15 are "NO" because they are dependent upon assessments being done.

1. A development checklist is a sequential listing of developmental skills. Ask to see a copy.

2. An annual calendar is the teacher's document/record of two (2) past and/or projected dates for child assessments. If item 1 is "no", then this item will scored "No" as well.

3. You must see a schedule for written assessments of the children, indicating days and times. It is fine to use an old schedule, as long as it is not more than a year old.

4. These items refer to a classroom (skill) chart. This chart refers to an organizational chart that provides space for the names of the children in the classroom, a sequence, scale, or checklist of developmental skills and a place to record the level of each child's progress in this sequence. They provide the teacher with a classroom-level, working system. Some items refer only to the availability of this chart and others refer to its use. A collation of individual assessments is not sufficient. These charts do not need to be posted.

5. There is written evidence that the information from the chart (see item 4) is summarized at the level of the class of children. This may be as elaborate as percentages of

children that have reached various milestones, as a whole, is below/at/above expected developmental level.

6. There is written or verbal evidence that the information from the chart is used when planning activities for the children, such that, for pertinent activities (not for the entire day) children are grouped according to skill level. A good question would be, "How do you decide how to group the children for activities that involve particular skills, such as manipulative or reading abilities?

7. There is written or verbal evidence that the information from the chart is used to plan activities that are sensitive to the developmental levels represented in the classroom. You might ask "Is this chart used when you plan activities for the children?" If yes, "How?" Listen for evidence of tailoring activities to the various levels of skill that are represented.

8. You must see a file for each individual child that includes an individual assessment, samples of the child's work, individualized notes from the provider, and notes from parent conferences. At least three of these materials must be included, but the individual assessment and notes from parent-teacher conferences are musts. If neither of these are in the file, this item is a NO.

9. There is written evidence for an individual (specific) child with special needs, describing the nature of the child's handicap or disability.

10. The focus of this item is on the procedure. Elements of this procedure might include who to contact, under what conditions, type of information to provide, format for follow-up, format for parent communication, etc. All components of the description need to be there for a "yes". By procedure it is meant: a system of whom to contact, under what conditions, with what kind of parent follow-up, with what format - written or verbal. It is ok if the director seeks the referral, but ask the director what her system is. Again, the issue is intentionality: is there a system that everyone knows how to use (including the parents)? It is OK if the caregiver indicates she would modify the procedure based on parents' personalities, as long as the key ingredients are present.

11. If there is only one teacher, give credit for this item. If there are more than one teacher, you should code "no" when there is no evidence of helping. It may also be the case that one teacher actually interferes with the other by, for example, leaving the room when another teacher needs help or redirecting children away from an activity planned by another teacher.

12. There is written or verbal evidence that the teacher is informed about the services or treatment received by specific children with special needs at least once a month. You must be sure that the teacher receives this information.

13. You must see written notes that were shared with the parents, and they must include information about the child's developmental progress, as well as anecdotal or more systematic information about the child's actual experiences in the classroom.

14. This calendar does not need to be posted. It needs to indicate how many and which times during the year will be devoted to individual parent-teacher conferences.

15. Following from item #9, these conferences must occur at least twice per year, and should follow (within one month) the child assessments.

16. You must see written notes that were shared with the parents during their parent-teacher conferences, and they must include information about the child's developmental progress, as well as anecdotal or more systematic information about the child's actual experiences in the classroom.

17. A chart or list refers to a standard form with specific places to record the individual child's information and includes at least sleep schedules and nutritional needs. This should be a standard pre-printed form, not just sheets

of paper or a notebook, unless it is obvious that the notebook is used everyday and contains the same information as would be on a standard form. The issue here is intentionality--whether there is a formal system with prompts for recording information about the children. It should be readily available and used consistently over time.

18. You must obtain written or verbal evidence (feel free to ask parents) that parents receive individualized or group notes from the providers at least every month describing the children's experiences in care. A monthly calendar is a YES.

CENTER PHYSICAL ENVIRONMENT

These items are adapted from Wachs (1986).

1. Code "YES" if there is a place for a child to escape to. It should afford a reasonable amount of privacy, away from traffic and from major sources of noise. This does not necessarily mean that the child has his/her own room. A loft or pillow corner would count as a "YES." It also does not necessarily require a "permanent" place; a quiet space can be created as long as it meets the criteria outlined above. If there is a separate nap area in a room divided by a partial wall this does count as a separate nap area, as long as nonnapping children are not allowed in.

2. Crowding refers to the number of children and adults per available floor space. We have deliberately not

quantified this item. Use your own judgment about whether the spaces where care for the target child occurs are crowded, taking into account the child's freedom of movement.

3. Again, use your own judgment about whether the space is cluttered and disorganized. Consider the arrangement of toys, other materials, and furniture. Take the child's point of view and ask yourself if he/she experiences an environment in which toys and materials can reliably be found in the same place from day to day, rooms are consistently arranged, and there are not so many toys and materials as to be over stimulating/overwhelming.

ADULT NEEDS

1. An adult restroom and lounge are available, separate from children's activity areas. The lounge may be used, however, for children's activities on an occasional basis. The room contains adult furniture. Individual storage for teachers' belongings is available in the classroom or central storage is available in the lounge.

2. A professional library with current materials on a wide variety of subjects is readily available. Readily available means at the center (may be in the director's office) or in an adjoining building.

3. Regular staff meetings, which include staff development activities, are held. Regular means at least once a month.

Off-site inservice training cannot substitute for staff meetings.

4. An adult group meeting area and conference space are available. Dual use must not interfere with meeting and conference scheduling, or the conference area is separate from the children's activities areas and other dual use. "Dual use" implies a high probability of scheduling conflicts. So, for example, in a church-housed center, if staff meetings are held during the week in a room that is also used by the church on week-ends, then this is not dual use for our purposes. If a center classroom is used for parent meetings and conference that occur only after-hours, then this is not dual use. In contrast, sometimes you will be told that a classroom is used for staff planning when the children are on the playground or taking naps. This is dual use, because there is a high probability that on any given day, one child will be too sick to go outside, or one child simply will not go down for a nap and so has to remain in the classroom.

5. Parent/staff information is exchanged at regular intervals through, for example, parent conferences, newsletters, bulletin boards. Regular means an on-going basis (bulletin board) or at least monthly (newsletter).

6. Parents are made aware of the approach practiced at the facility through, for example, information sheets, parent

meetings, etc. Parents may have input into planning and evaluation of the program.

7. Parents are welcomed to be a part of the program through, for example, eating lunch with the child, sharing a family custom with the child's class. Parents may be involved in decision making roles along with staff. Code "YES" if parents are given the opportunity to be part of the program, even if they do not take advantage of it.

b. Assessment profile for family day care

SAFETY AND HEALTH

Again, one hazard constitutes a "NO" item.

1. This item pertains to the bathroom or diapering area only. Items which are hazardous to children are not within reach of children. Dangerous items cannot be obtained without extraordinary means (such as pulling a chair and climbing). "Out of children's reach" means reasonably secured based on children's ages and abilities to get to hazards. If the child must go to extraordinary means to reach dangerous items then that are considered secure. This is one item when it is appropriate just to ask "Where do you keep cleaning supplies and sharps?" Ask her to show you where they are stored (observe).

2. This item pertains to the bathroom only. The emphasis of this item is that a child cannot lock a bathroom door.

If the door handle lock is covered with a child-proof cover to prevent locking, score this item "YES." But if the door can be locked, even though a key is within reach, score this item "NO."

3. Electrical appliances (such as toaster, record player, radio, etc.) cannot be obtained without extraordinary means (such as pulling a chair and climbing). Electrical cords are not visible or taped, tacked to prevent pulling or tripping. This item pertains to the kitchen and all other areas of the home which the children are observed to use. Cords can be taped, tacked, or out of sight.

4. Handles should be turned all the way toward back of stove.

5. See item #1. Item 5 pertains to the kitchen area only.

6. Cleaning agents (such as ammonia, detergents, bleach, etc.) are not within reach of children. These items are in a locked cabinet or cannot be obtained without extraordinary means (such as pulling a chair and climbing). Child-proof safety latches are considered to be "locks." These agents are not stored on counter tops where food is prepared or in cabinets where food is stored - not in any proximity to food.

7. Cribs/beds/cots/mats are located out of reach of heaters when in use by children (i.e., at least 2 feet away).

8. See item #1. Item 8 encompasses all other areas of the home that children are observed to use.

9. Pathway is a passageway in which children and adults walk or crawl as they go from one place to another within or between rooms. Toys in use are not necessarily considered hazardous.

10. Baseboard heaters typically do not get hot enough to the touch to be dangerous, so, in most instances, a home would get credit for this item if it has baseboard heaters. Heaters that tend to get hot are space heaters, old radiators, kerosene and electric heaters, and woodburning stoves. If these are protected from the children's reach, then give credit. If not, code as "no", even during warm weather.

11. Inaccessible electrical outlets are located too high for the child to reach without extraordinary means or are located behind furniture too heavy for a child to move.

12. Self-evident

13 and 14. Good repair refers to free of potential safety hazards for the child.

15. Written emergency procedures and an evacuation diagram should be posted for all pertinent hazards which should be determined by the local geography or region of the country. For example evacuation procedures for flooding may not be a presenting hazard but earthquakes may be. In this case

earthquake evacuation procedures should be posted but flooding evacuation procedures are not. Evacuation procedures should include specific directions for relocating non-mobile infants. A simple diagram is not sufficient, a written procedure (such as: should windows be opened or closed, take parent phone numbers, check specific areas of the home for children, etc.) for relocating infant is posted. The diagram and the written procedures are intended for adult reference. Should include diagram and written instructions for adult use. The plan should include instructions for what to do with nonmobile infants. Ask about the amount of time it takes to evacuate.

16. All of these numbers must be posted, so a home that only posts 911 would get a "no" unless (a) parent numbers are also listed, and (b) 911 is the centralized number for a doctor, hospital, fire, and poison control. Generally, poison control has a separate number that would need to be posted to get credit. To determine whether the numbers are current, you will need to use one of your non-leading questions. Try, "Gee, parents' numbers change so often, how do you keep up with this?" Then, you need to interpret the provider's answer. If she says. "Oh, it often gets away from me", code "no". If she has a good answer, give her credit.

17. Any stairs that are accessible to the children must be safe, as defined in the item. This includes stairs on an outdoor deck if children have access to the deck.

18. Soap and water is necessary, baby wipes do not adequately cleanse and may NOT substitute for soap and water. This includes hand washing after blowing a child's nose. Score "NO" for even one missed opportunity.

19. See #18.

20. Each disposable, or paper towel, is used exclusively for one child or for one adult to prevent the spread of germs. If cloth towels are used they are used exclusively by one child. (See center version.) When only one child is in care, make sure that linens are not shared with any adults.

21. These items must be used by only one child. There must be at least 1 personal item available for each child.

22. If more than one child uses a crib or cot, the linens must be changed between uses and the crib/cot must be labeled to indicate whose sheets, are on the crib/cot.

23. Self-evident. Ask the provider.

24. A disinfectant solution of 1/4 cup bleach to 1 gallon of water or other medically approved disinfectant is used. If diapering surface is visibly soiled it must be wiped clean first and then disinfected. The use of protective tissue to cover the diapering surface is insufficient.

Surface should still be disinfected unless tissue has a nonporous, plastic backing. Must be disinfectant such as quarter cup bleach to gallon of water mixed daily or a hospital-approved disinfectant -- not Lysol, soap & water, or baby wipes. Paper or waxed paper covering diapering surface not sufficient unless hospital-type plastic-backed covering. Ask "What is the solution you're using to disinfect the diaper area?" if you cannot identify it.

25. Persisting odors are odors that linger more than 15 minutes. Lingering means odors linger/persist more than 15 minutes.

26. This training must be current within the past two (2) years. Ask to see document; if it's not available, take her word for it. Must be infant CPR. Code "no" if caregiver's CPR or First Aid Certificate has expired.

27. It is not necessary that this information be posted. Provider must have ready access to this information, it may be in a file. Instructions refers to policies and procedures for when and how to provide treatment, or notification of parents, or isolation, etc. A first aid manual plus information on illnesses is okay.

LEARNING ENVIRONMENT

Code per "dominant mode."

1. Accessible refers to the child's ability to physically reach the toys and allowed to access, or use the toys; has

permission to select without adult assistance. Must be accessible and allowed to use freely. Do NOT count toys that the children bring from home.

2. Containers can be plastic baskets or boxes and should be of a size from which the child can manage to obtain a toy or replace a toy. Shelves and containers should be at a level that is reachable to the child so as to encourage child exploration.

3. Code "yes" if toys are grouped conceptually (music toys, fantasy corner, manipulative, art materials), or by age, or any other obvious system.

4. Variety refers to three (3) types of toys and materials for outdoor use. You may count toys that you observe to be taken outside, i.e., a scooter.

5. Provider must be observed to interact with the children during outdoor play. Just watching or talking to the children is insufficient.

6. Close means within arm's reach of the child.

FAMILY VERSION OF PROFILE

Scheduling

1. Quiet activities are reading, listening to music (not dancing), working puzzles, drawing. Active activities are any indoor active activities or outdoor activity that uses equipment, dancing, tumbling, throwing balls, using walkers or swings, acting out roles.

2. You must see the children outside, unless the weather does not permit. Outside means just this -- it can be a walk, time in a playground, etc.

3. You must see the provider spend 1-to-1 time with each child in her care. If someone is left out, ask the provider what that child did before you arrived and will do after you leave and listen for 1-to-1 activities.

Curriculum

1. Materials that encourage small muscle exploration are readily approachable. There should be three different types (not 3 of the same item). This would include puzzles, busy boxes, snap beads, small blocks, etc.

2. Materials that encourage language development are readily approachable. There should be three different types (not 3 of the same item). The items contain useful examples.

3. Materials that encourage drama play are readily approachable. Again, 3 different types of materials must be present (not just 3 dresses or 3 hats).

4. A special activity is a pre-planned activity that offers the children a novel experience that would not occur on a routine basis. This may include a visiting musician, a walk to a museum, a special art activity, bubbles, etc.

5. This system of toy rotation removes toys that infants have lost interest in and introduces additional toys that may have been stored or that are new. The emphasis of this item is the existence of a system or strategies to maintain the children's interest.

6-13. You must see these teaching techniques. If it happens once, code "yes". They do not need to be directed at the target child, necessarily. Indoor and outdoor activities count equally towards these items.

9. The use of the term "opportunities" in this item captures both materials and activities. Relevant materials must be used intentionally for illustrating or teaching abstract concepts for this item to get credit. Thus, crayons don't necessarily get a "yes", but if they are used to teach color labels, or matched to other colored items, then the home would get credit.

INDIVIDUALIZING

Individualizing pertains to all the children in the room/arrangement, not just the target child.

Code per "dominant mode"

1. Cubbies and containers may be baskets, boxes, bins, tote/diaper bags, or shelf-like structures with individual compartments. Code "no" for a child having his/her own room or closet.

2. Self-explanatory.

3. A chart, or form, includes child's name, date, description of child's behavior or needs. Variation refers to change in the child's routine behavior or needs with regard to sleeping, eating, toileting, end of day pick-up, etc.

4. This may take the form of written notes, a more formal form that is computed each day, or a verbal exchange. It is crucial that it happens each day, so if you see a parent pick a child up and there is nothing said about the child's experiences (not just "good-bye" or "he did well today") -- meaning what the child did that day - code "no".

5. Not a group presentation, but one-on-one with separate parent(s).

I. HOME Observation Procedures

See Chapter 21, III, I Sections 2 and 3 for details on the administration of HOME in child care arrangements. In general, the interview items from the HOME, the items involving observation of physical aspects of the environment (e.g., learning materials, safety issues) and items involving observations of caregivers behaviors not directed at the child (#4, #5, #6) can be scored based on information obtained at any time during the 2 day visit. Scoring of items involving caregiver behavior involving the child (#1, #2, #3, #8, #9, #10, #11, #12, #13, #14, #16, #17, #29, and #35) should be based only on observations made during the first two hours of the visit on the second day. Indeed, there is a preference for doing the interview portion of the child care HOME during the observation period on the second day just prior to doing the other interviews for the visit. Rather than sitting down at the outset and asking all of the questions, you should ask them as the visit progresses. This gives you the flexibility to raise an issue at an opportune moment. Towards the end of the second visit, go over your CC-HOME form to make sure all items are scored. As with the PROFILE, once an item is scored it is best to consider it final. Otherwise you will spend much of your time coding and recording and you have other data collection to complete. This also implies that you should not complete an item until you are confident that you have sufficient information on which to base your judgment.

1. Basic Concepts

The acronym chosen for the HOME Inventory (**H**ome **O**bservation for **M**easurement of the **E**nvironment)--effectively expresses many of the major concepts underlying its development and represents some of the skills that will be needed by any person who uses it.

a. Child care home

The data to be gathered are collected in a home, not in an office, laboratory, or child care center. The HOME subscribes to the philosophy that you can truly appreciate a child's behavior and development only if you have experienced the child's most intimate and powerful environment first-hand. A child-care home visit provides a richness of detail and a complexity of interchange that no interview can fully reveal.

b. Observation

Scoring for many of the items is based on what is observed during the visit, so obviously the HOME Visitor must be a good observer. Most of us think we are good observers, but often come away from a conversation with another person unable to report the color of that person's eyes or hair. Some concentrate so effectively on small details that aspects of the background are totally lost. One thing training in the use of HOME will do is help the user become a better observer of some of the small transactions between children and their parents and caregivers. Moreover, persons who are good observers have a head start in becoming proficient users of the instrument.

c. Measurement

The HOME is not just an informal data-gathering process; it is a systematic measurement of the caregiving environment. The measurement philosophy of HOME recognizes that skilled observation alone is not enough to allow a procedure to be useful for research purposes--or even for some clinical or educative purposes where precision of information is essential. Always there remains the onerous task of somehow converting the observations into quantifiable units. In the HOME we have used the simplest possible measurement system (counting) and the simplest type of item (binary). By observing whether certain events occur (parent praises child) and, if so, how often (at least twice), and then simply counting up the total of the designated behaviors, the amalgam of impressions and feelings is translated into a unified measurement system. For some clinical uses of the Inventory, one could stop short of this step; for research purposes, however, a commitment to measurement is necessary. When working with a caregiver, one is sometimes tempted to fall back on general impressions or feelings about the caregiver. There is an urge to give "credit" to those we like or feel empathy for. Lost in this process is the value of careful, objective description--the kind of information that leads to fuller understanding and more effective planning in behalf of the child and caregiver.

d. Environment

Although the Visitor goes only to the child's home-based child-care setting, in the process an effort is made to appraise the quality of the broader developmental environment. Certainly during the early years, home, family, and caregivers constitute the most important environment that exists for most children.

However, information is obtained in the course of the visit which helps to give a picture of the milieu in which the child's caregiving environment is embedded and the extent to which these experiences are strengthened by outside contacts likely to be meaningful to the child (e.g., trips to grocery store, visits with relatives).

These four components--actual visits to the home, a preference for observation as a means of obtaining information, a commitment to measurement, and a recognition of the importance for development of the environment--represent the major vectors of the philosophy which guided the development of the instrument.

2. The Interview

One important aspect of the procedure which is not covered by the acronym HOME is the interview that is necessary to obtain information to score some of the items. On the Infant-Toddler form of the Inventory, only one-third of the items will require supplementary interview data (although sometimes the visitor will have to ask questions about some of the toys, all of which may not be visible during the visit). Thus, an essential skill for persons who will use the HOME is good interviewing technique.

Much has been written about interviewing in human services, and anyone without training and experience in interviewing should begin by reading some of the widely-used materials (Garrett, 1958; Shulman, 1978). Of particular help would be a document such as the Interviewer's Manual published by the Survey Research Center of the University of Michigan (1969). The anonymous authors of this widely-used manual remind us that interview respondents must (a) find an interview pleasant and satisfying, (b) consider it important and worthwhile, and (c) not regard it as something to be feared or that might result in personal harm (e.g., a damaging report to the Welfare Department). Although these precautions were written with survey research in mind, users of the HOME can profit from them.

3. Administration of the Child Care HOME

As already indicated, CHILD CARE HOME items are sometimes based on information supplied by the caregiver and sometimes on direct observation of what transpires during the visit. Sometimes with older children, the information actually comes from the child. The Visitor will be observing and interviewing at the same time, but the instructions can be simplified if these two aspects of the procedure are separated for discussion.

a. The interview

For this project, we recommend a standard interview for eliciting the information necessary to score the items which require information that cannot be obtained by observation. We also expect to have good interviewers. A good interviewer is a person who can be at ease in the situation, can put the caregiver at ease, can easily adjust subsequent questions to responses of the caregiver, and can ask questions in such a way as to avoid putting the caregiver on the defensive and thereby causing her to second-guess the Visitor as to what is the "right" or "expected" response. The Visitor's goal is to be objective and accepting as opposed to approving or disapproving. This is essential if she is to find out how the caregiver feels and what the caregiver does with her child or children rather than what the caregiver thinks the Visitor wants her to say.

Before actually conducting an interview, it is important to be completely familiar with the items. This will help the Visitor be more relaxed and will help the person with whom she is talking feel less "on stage." In fact, we highly recommend that, prior to actual use of the instrument, prospective Visitors accompany a person already trained in use of the Inventory.

b. General Style

Obviously the Visitor must be careful not to ask questions in a threatening or judgmental manner. For example, rather than ask, "*Do you ever read stories to CHILD?*" it is preferable to ask, "*Do you ever manage to find time to sit down and read to her?*" If the caregiver answers affirmatively, the Visitor can explore further by inquiring, "*How often does he like you to do that?*" You will note here that the burden of frequency is put on the child, not the caregiver; however, in her answer she will inevitably describe her own behavior, e.g., "*He would like me to sit and read to him all day, but I can't do that. I tell him, 'I've already read to you, and one book a day is enough!'*"

Although it is a good idea to develop techniques for avoiding seemingly accusatory questions, the Visitor should not be so concerned about subtle wording as to ask the question in a way that will elicit tangential and irrelevant answers to the items as worded. Reassurance for timid Visitors should be found in the fact that most caregivers believe that what they do with and to the children is for the children's own good, and they often report with pride actions that you might expect them to try to conceal.

Most of the information necessary to score the Inventory will flow forth fairly smoothly without the use of precisely-worded probes. It is better to get the information as the caregiver provides it rather than through the use of an invariant interview procedure. However, it is important to check each item before leaving the home. It is very easy to think that you have obtained all the necessary information, when actually you omitted some items. The single most common mistake made in using the **HOME** is that the Visitor **does not get enough information** to score all the items. We feel that it is advisable to call the caregiver's attention to your checking of the items rather than have her make an inquiry about it. A simple statement such as, "*I'm jotting this down because if I don't I tend to forget some* *of the things you tell me,"* will usually handle the situation nicely. Caregivers know you are there to learn about the child, so they are rarely concerned that you take notes or check your information before leaving.

c. Exceptions to standard procedures

Whenever one tries to define standard conditions under which procedures should be carried out, one immediately has to face the inevitability of more exceptions than standards. Such has certainly been the fate of HOME. In designing the instrument we opted for binary (either-or) choices rather than ratings along a continuum, for arbitrarily selected cutting points ("...no more than one instance of physical punishment occurred during the past week") rather than estimates of quantity and severity ("...uses physical punishment extensively, moderately, minimally"). We hoped thereby to eliminate a great deal of the subjectivity ordinarily associated with similar inventories. Accordingly, with each revision the items became more and more concrete and, we hoped, objective. However, significant objectivity for one situation reads "does not compute" for another.

For example, many of the items begin "Caregiver does..." something or other (reads to child, encourages developmental advance, provides toys, etc.). As discussed earlier, this choice of wording reflects the orientation that the caregiver is indeed an important person in the life of the young child and will be a major interpersonal influence on the child's development. Of course, this does not mean that the caregiver will supply all the care provided for the child. For example, in homes with older children present, many of the activities covered by Inventory items might occur in the life of the child but might be provided by an older child. Some caregivers have responded to items such as "Caregiver reads stories at least three times weekly," with a statement such as, "I don't, but the older kids do."

The frequency with which such exceptions occur requires the articulation of an overriding principle which will help the user make decisions about the scoring of individual items. The intent of the assessment procedure is to get a picture of what the child's world is like from his or her perspective--i.e., from where the child lies or sits or stands or moves about and sees, hears, smells, feels, and tastes that world. If that principle is kept in mind, then the Visitor will not have to split hairs to score some of the items. The Inventory is attempting to assess the Child Care environment from the perspective of the child and is not exclusively appraising the caregiving abilities of the caregiver. Toys bought for other children but made available to the key child can still help in the acquisition of eye-hand coordination. Books read by an older child still foster language acquisition. In order to obtain an accurate picture of the child-care environment, it is critical that we learn a great deal about the input supplied by the caregiver(s). However, a still broader portrait of the supportive qualities of the setting can be obtained by evaluating each exception in terms of the simple question: What is in it for the child?

d. The observations

Throughout the session, the Visitor will be observing the behaviors of the caregiver and those aspects of the physical environment which comprise Inventory items. However, it is not a good idea to wait until the interview is completed to try to make a decision as to whether the behavior has actually occurred. Familiarity with the items and with the level or quantity of behavior chosen to designate success (e.g., kisses child once, verbalizes twice, etc.) leads to a general alerting on the part of the Visitor to such behaviors as they occur. A notation should be made on the Inventory form as quickly as possible. The recommended review of the Record Sheet at the end of the interview provides an opportunity to make certain that you have indeed paid careful attention to the kinds of behavior referred to in the observation items. The Visitor may have forgotten to praise the child in order to note the caregiver's response. If so, a quick check of the Record Sheet will serve as a reminder to set up the situation so that the caregiver's response can be observed.

Some people who use the Inventory have reported that they feel frustrated in making their observations for the interpersonal items because the really outstanding caregiver--the caregiver who verbalizes to the child 20 times during the visit rather than twice, the one who glows rather than smiles when the child is praised--does not receive a higher score than the one who is barely above the cutting point. In defense of this perceived weakness of the instrument, we offer a reminder of the major reason behind the development of the Inventory--the identification of at-risk environments where both the children and the caregivers could benefit from carefully planned intervention. You will have an opportunity to give the really terrific caregiver 4; in the Qualitative Ratings.

One final word should be said about reliance on observation versus interview for the items relating to play and learning materials in all versions. It was originally intended that these be observational rather than interview items. In most cases, this is how the items are scored. However, the visit usually takes place in the living area of the home or apartment, and frequently toys are not stored in this area. As long as the child is present during the session (which is *de rigeur*), certainly some toys will be brought in for the occasion. Furthermore, they will most likely be the ones which the caregiver feels are "good for the child" and will be the very ones the Visitor will need to observe. However, it is acceptable to ask about other categories rather than demand to see the objects. If for any reason the Visitor feels that the caregiver is not clear on the type of toy asked about but says that she has bought one for the child, the Visitor might ask her to get it and let the child show how he or she uses it. This can easily be handled with good taste in such a way as to cause no discomfort to either the caregiver or the Visitor.

e. Scoring

All items on all forms of the Inventory receive binary scores--yes or no. Indicate "yes" with a "+" and "no" with a "-". No attempt is made to make finer gradations. The decision to employ a simple "yes - no" approach to scoring was made after careful consideration of many approaches, including the use of Lickert-type and Guttman-type scoring procedures. This binary format was chosen because it was difficult to come up with meaningful ways to operationalize Lickert or Guttman formats for each of the items. Rating scales such as "Always to Never" or "To a great degree to not at all," etc. were hard to fit to many of the items. Nor was there basis in the literature for *a priori* weightings for each item or a sample good enough to help establish empirically-derived weightings. This is not to say that other item formats are totally unfeasible or that the binary format is ideal for all items. In fact, the breakpoint between "yes" and "no" was established for some items with only a small amount of information to guide the choice. However, this format seemed to provide the best fit among the available choices.

It is important to keep in mind the fact that all observation items refer to the contemporary situation--i.e., to conditions that prevail at the time of the visit. The time period covered by interview items varies; however, this is clear from the content of the item.

Except for those items where scoring criteria leave no room for leeway, the standard rule of thumb to apply in scoring is "what is appropriate for the target child." Toys useful in promoting hand-eye coordination in a 12-month-old are not the same as toys useful in promoting hand-eye coordination in a 24-month-old. Decisions about scoring must be made from the child's point of view. It matters not that the caregiver's "heart is in the right place" or that "she is doing a great job under the circumstances." What matters is what gets to the child.

The final thing to consider in scoring is to stick to the content of each item. HOME is a standardized procedure. Like most other measuring devices, it contains a sampling of items from a much broader domain. Nonetheless, it is that particular sample that forms the "standard" of comparison. If the item says "Caregiver takes child to grocery store," visits to a department store do not count.

Once individual items are scored, it is a simple matter to derive scores for subscales and for the total scale. The number of "Yeses" is simply added to get the score.

f. Completing the form

It is advisable to complete the coding of the Inventory before leaving the house; do not trust your memory. Before leaving the home, the Visitor should have placed either a plus or minus mark alongside every item on the Inventory.

The items involving observation of the physical environment (Learning Materials, safety issues) and items involving observation of caregiver behaviors not directed at the child (#4, #5, #6) can be scored based on information obtained anytime during either visit. However, scoring items for caregiver behavior involving the child (1-3, 8-14, 16-17, 29, 35) should be based only on observations made during the first two hours of the second visit.

4. Instructions for Individual Items

In the previous section, **General Instructions**, basic procedures for conducting the interview and making the observations necessary to score all versions of the HOME were given. In this section, specific instructions pertaining to the CHILD CARE HOME (CC-HOME), Infant-Toddler version are presented.

For the experienced user of the HOME, the wording of the items on the Record Form will stand alone. However, until a potential user is completely familiar with the procedure, some amplification of precisely what is intended by each item is necessary. Such amplification for all items on the CC-HOME is provided in this section. Because of their simplicity and binarity, the items are about as unambiguous as any scale developer can hope to achieve. However, language being what it is, some residual ambiguity is inevitably present in any abbreviated description of complex interactions or events. Accordingly, we have attempted to clarify precisely what is meant by each item in order to enhance reliable use of the Inventory.

a. Responsivity

This factor is defined as describing the extent to which the caregiver responds to the child's behavior, offering verbal, tactile, and emotional reinforcement for desired behavior and communicating freely through words and actions. Some of the items which loaded on this factor are based on responsivity of the caregiver to the Visitor rather than directly to the child. Obviously such items are based on the assumption that the caregiver's style of responding to the Visitor will reflect habitual patterns of social response and will therefore predict interaction modes between caregiver and child.

1. Caregiver spontaneously vocalizes to child at least twice. "Vocalizes" refers to any sound or words emitted by the caregiver except scolding or chastising. For example, she may say, "S-s-s" or "Sweet baby," or any random words or sounds. In order for this item to be scored positively, the caregiver's vocalizations must have occurred spontaneously

as opposed to having occurred in response to some vocalization by the child. If the caregiver scolds or derogates the child repeatedly (i.e., far more than twice) but does not otherwise converse with him or her, this item should be scored negatively.

2. Caregiver responds verbally to child's vocalizations or verbalizations. Again the caregiver's response may be either a complete word or words or merely clearly differentiated sounds, e.g., "ta-ta," "tsk-tsk," or "You talking to me?" The key factor here is that the caregiver is responding to the child's vocalization, not ignoring it. If the child does not vocalize during the interview, thereby denying the caregiver an opportunity to respond, the score would still be "No."

3. Caregiver tells child name of object or person during the visit. The caregiver does not have to say, "That's an apple," or "We call this a purse," in order to obtain credit on this item. What is being measured here is the adult's sensitivity to the child's search for labels of objects around him. Credit for this item may be earned by a pattern of emphasis with the voice. For example, "*Do you remember Miss Jones?*" referring to the Visitor. She has "taught" the word with her intonation and supplied a referent for the child.

4. Caregiver's speech is distinct, clear, and audible. A positive score on this item is determined by whether the Visitor is able to understand what the caregiver says. This item should not be interpreted as meaning that dialect usage mandates a negative score. What is important is whether the Visitor can understand and communicate with the caregiver.

5. Caregiver initiates verbal interchanges with Visitor. In order to be credited on this item the caregiver must demonstrate some initiative in asking two or three questions or making spontaneous comments that go beyond the bare minimum needed to give an answer. It is not necessary that she do this on all questions; however, occasionally she should take the initiative in the conversation and be a little wordy.

6. Caregiver converses freely and easily. In order to receive credit on this item, spontaneity is not as important as fluency. That is, the caregiver will be talking about things that are very close to her, and it should be very easy for her to express her ideas on this subject. A "No" would be given to a person who tends to speak in one word sentences or to use headshakes when they would do. An occasional exception would not earn credit; the characteristic speech pattern should be noted.

7. Caregiver permits child to engage in "messy" play. This item was developed as one that should cluster with others in

the general category of acceptance. However, it had a higher loading on this Responsivity factor and has accordingly been placed here. Certainly the caregiver who manages to allow a little messy play without getting too upset is responding emotionally in an appropriate manner. To be given credit, a caregiver does not have to disavow concern with wanting to see such behavior disappear from the child's repertoire; she must merely be willing to tolerate it occasionally. Included may be such things as playing with sand, mud, water, finger paints, or, for young babies, food.

8. Caregiver spontaneously praises child at least twice. In scoring this item, do not hesitate to read the caregiver's affect--any achievement reported with pride should count (can dress himself, has a good disposition, etc.). However, occasionally a caregiver will indicate approval of the child's behavior by making what appears to be a negative statement--"*I tell you, this kid is really bad.*" If she says that with a smile on her face and immediately follows the statement with some rather remarkable achievement--"*Would you believe he climbed out of his crib, got his bottle, and climbed back in all by himself?*"--from which one can obviously infer that she is proud of him, then consider this one instance of praise. Do not credit this kind of semantic reversal if it stops with the negative

term; score only if some proof of positive feeling is offered, and only if the compliment is spontaneous.

9. Caregiver's voice conveys positive feelings toward child. What you are looking for here is evidence that the caregiver feels good about her child--sounds animated when speaking about him or her, does not use a flat or querulous tone of voice, etc. Generally the comments will be accompanied by positive facial expressions.

10. Caregiver caresses or kisses child at least once. Under "caresses" would be included a hug, a stroke of the hair, patting an arm or leg, reaching out affectionately and touching the face, etc. Blowing a kiss as well as actually establishing physical contact may be counted as a kiss. Simply touching a child does not constitute a caress.

11. Caregiver responds positively to praise of child offered by Visitor. In order for the caregiver to earn credit on this item, the Visitor must remember to offer some praise of the child. Make certain that your praise is genuine--i.e., do not try to force praise that you do not feel as you look at the child. Usually you will have no trouble deciding how to score this, as a caregiver might agree with you, add more facts to encourage you further, beam, etc. However, sometimes you will get little more than a "Thank you" said without feeling or an embarrassed smile. If so, find more than one occasion to praise the child. If you consistently

get a response that shows no feeling or pleasure, then score negatively. Be alert to observe the caregiver's facial expression when you praise the child.

b. Acceptance

This factor covers the caregiver's acceptance of less than optimal behavior from the child and the avoidance of undue restriction and punishment.

12. Caregiver does not shout at child. A positive score on this item requires that the caregiver not raise her voice to a level above that required by the distance between her and the child.

13. Caregiver does not express overt annoyance with or hostility to child. A caregiver would receive a minus score on this item if she complains that the child is hard to take care of, that he is wearing her out, if she calls him "bad" without the affectionate joke described above, says he will not mind, and so on. Examples that would fail to receive credit would be remarks such as, "I don't know what I"m going to do with this kid," or "This kid is driving me up the wall." A caregiver might tell a child to stop doing something several times during the interview and still be credited for this item if her general tone is positive.

14. Caregiver neither slaps nor spanks child during visit. Occasionally a visitor will feel that she does not know

whether a caregiver is playing with or seriously slapping or spanking a child. The best guide to use in such instances is the child's behavior. If the child reacts with pleasure or happiness, chances are this represents a style of positive interaction between her and the caregiver. If she frowns or looks unhappy or whimpers or cries, you can feel pretty confident that, however the caregiver intended it, she does not perceive it as pleasurable. Score "minus" accordingly.

15. No more than one instance of physical punishment during past week. Most caregivers define physical punishment as spanking; some apparently seem to regard it as true punishment only if something other than the hand has been used. Some caregivers regard restraint and shaking a child also as involving physical punishment. Our definition includes all of the above, even if the caregiver has a different idea (i.e., doesn't count unless a paddle or belt is used). If the child is hit, shaken, pushed against a wall or object, paddled, or just poked hard with a finger, score as physical punishment.

16. Caregiver does not scold or criticize child during visit. This item is obviously similar to #13 above. However, the main difference is that on this item the caregiver must make the negative remark directly toward the child. That is, "You are a bad girl," not "She (speaking to Visitor) is a

bad girl." If such a remark occurs one or more times, score "-"; otherwise score "+."

17. Caregiver does not interfere with or restrict child three times during visit. Restrictions and interference here refer to such things as: taking a toy away from a child; putting a child who has climbed up on the sofa back down on the floor; putting a child who is crawling around the floor into a playpen or crib; slapping a child as he starts to pick up the Visitor's handbag. In the last instance, the item would be applicable to both items #17 and #14. The restrictions may also be verbal--"Stop that"; "Get out of there." Do not code as interference any action taken to prevent the child from harming herself (e.g., running into the street).

18. At least ten books are present and visible. This item, and the one to follow, appear less faithful to the intent of the Acceptance factor than the others. Yet a *post hoc* explanation is always possible. Having books when there is a toddler present always poses a slight risk of having them torn or damaged, so their presence and availability identifies at least a willingness to cope with the child's curiosity and exploratory behavior--a clear form of acceptance. The same can be said for having a pet. A manipulable pet in the household of a toddler runs a

definite risk! Caregivers who allow this are clearly being accepting of immature behavior.

The word "visible" was added to this item to make it an observation and not an interview item. However, being able to observe whether there are books present in the home might require a request to go through the entire house or apartment without a spontaneous invitation to do so from the caregiver. In such instances, do not hesitate to ask about the books that are available. The item will help indicate whether the child is growing up in a child-care setting in which reading and having books around are valued. For example, there might be an encyclopedia on the shelf that has obviously not been read. Even so, credit would be given for the item, as the presence of the books indicates that they are valued. This item does not refer to children's books but the books should be located so a child can see them (not in a box in a closet).

19. There is a pet. It seemed incredible that this item could have any content ambiguity, but apparently some Visitors have had trouble deciding whether one or another type of animal that has temporary residence in the setting can truly be called a pet. In our definition the word refers to an animal that is taken care of in the child-care setting (including the child's own home) and the child can play with or look at--i.e., one that stays in the setting on a

semi-permanent rather than a temporary basis (such as a dog, cat, bird, turtle, goldfish, hamster, as opposed to a captured grasshopper, a lame bird, or a jar full of lightning bugs, etc.).

c. Organization

This factor refers to the extent to which there is regularity and predictability (without monotony) in the caregiving schedule, to the safety of the physical environment, and to the inclusion of community services as part of the caregiving support system.

20. Caregiver is one of not more than three regular substitutes for child. There is really no need to inquire about this, in that the mother will already have supplied the information. However, the item is included here because the wording is slightly different from that on the regular Inventory form ("Child care, if used, is provided by one of 3 regular substitutes"). The mother is more likely to have the information necessary to score this than the caregiver, unless the caregiver is the father. In order to get the information during this session, ask, "*Are you the only person who takes care of CHILD while his/her mother works?*" If the answer is negative, follow up with, "*Who else does this?*" Then ask, "*How many people are there altogether, including you?*" If the caregiver is joined by other people

for part of the day on a regular basis (e.g., older sibs who show up every day at 3:30 and spend some time with the child, a neighbor who comes in regularly each morning for coffee, etc.), do not count these as extra caregivers unless the primary caregiver leaves the child totally in their care during those times.

21. Child is taken on an outing at least once a week. "An outing" can be broadly defined. It may be a walk to a neighborhood park to use the slide/swings. It may be a trip to the grocery store, a visit with a neighbor next door who has a child or children. It should be more than merely going out in the yard to play.

22. Child gets out of house at least four times a week. The infant/toddler may be taken no farther than the yard in order for credit to be given. The intent of the item is exposure to sounds and sights and objects and people other than those routinely available within the house or apartment.

23. Caregiver has an emergency medical and/or accident plan. This is a requirement for all registered or licensed family day caregivers, so the visitor could ask to see the plan. For more informal arrangements, the visitor will have to ascertain whether the responsible caregiver has thought about this, has a plan, has phone numbers and names written down, etc. The visitor should ask, "*Tell me what you would*

do if you had an emergency with CHILD." If there is any reason to doubt the accuracy of the response, ask, *"Where do you keep your list?"* With this kind of probe, the caregiver will generally get it and show it to you.

24. Child has a special place for toys and treasures. This item will reflect the predictability of the child's environment. The special place may be a closet, drawer, a plastic basket, or even a cardboard box or paper bag. It need not be a fancy chest especially sold for children's toys. It does not have to be in a special room. The accessibility of the special place for either removal or returning toys by the child is the essence of the item. The special place does not have to belong exclusively to the key child; it may be shared with another child.

25. Child's play environment is safe. The Visitor should use her own good judgment in scoring this item. Examples of hazards are: broken glass lying around, furniture with wood splinters or exposed nails or pins, an uncovered rotary fan, boards with nails sticking out, unprotected stairs for a pre-walking baby, house so close to the street that child could not safely play in the yard, pot handles extending over edge of the stove, etc. Overcrowding or clutter would not count as a hazard unless it existed to the extent that it could injure the child.

d. Learning Materials

This factor deals with the provision of appropriate play and learning materials capable of stimulating development. The factor could have been called something like Toys and Equipment to Support Development. Historically, we did call it that and various other things at different times in the past. But in trying to shorten all the subscale labels, we settled on the true common denominator of the items included here--they are materials which, when used by the child, provide tools for the development and refinement of crucial skills which must be acquired during the infant/toddler years. Thus we have relabeled the subscale, Learning Materials.

In scoring items in this section, it is important to keep in mind the **developmental function** served by each type of play equipment mentioned. What is crucial is not whether the toys are shiny and new and expensive or whether they are home-made or hand-me-downs. What is important is whether they will allow the child to touch, feel, manipulate, move, listen, and have fun in the process! Also it is not critical who purchased the toy. What matters is its availability to the child.

For each of the items in this subscale, the child must have access to the toy or piece of equipment. If someone has purchased the toy for another child but the child who is the subject of the visit is prohibited from using it, then credit should not be given.

26. Muscle activity toys or equipment. Examples are crib, gym, ball, rocking horse, jumpseat, door swing, or any of the items mentioned in #28. If such equipment had not been provided by the caregiver but is available in the childcare setting, the item should be credited so long as the infant or young child is granted access to it. Also the item need not be identified by the caregiver as "belonging" to the child; it might be shared with other children. However, it must be available for use. Thus, for all the toy items, credit would not be given if someone had bought the toy for the child but it had been lost, broken, or stolen. In such cases it would not be available.

27. Push or pull toy. Examples are toy lawnmowers, vacuum or carpet sweepers, corn poppers, music boxes on a stick, xylophone that is pulled by a string, wagon, etc. Credit also a shoe box with a string attached, a real carpet sweeper (with which the child can regularly play), or a kitchen stool on wheels.

28. Stroller or walker, kiddie-car, scooter, or tricycle. These items are all self-explanatory--anything with wheels that a child can ride on or in, or a large wheel toy that the child can manipulate.

29. Caregiver provides toys for child to play with during visit. In order to be credited on this item, the caregiver must make some special effort to see to it that the child has

something interesting to do during the visit. If the visit is conducted in a room that contains a number of toys or the child's toy box, one should assume that the caregiver has taken special efforts to have something available to entertain the child during the interview. If, however, the child tires of what is available and begins to whimper or to ask for something to do, this item should not be scored unless at that time the caregiver makes some special effort to bring out a new toy or do something else to interest the child.

30. Cuddly toy or role-playing toys. This is an item that has a certain amount of age flexibility. For children up to about 18 months, a teddy bear or other stuffed animal or doll would provide the tactile experience presumably offered by a cuddly toy. For children between roughly 18 months and three years, any kind of doll or stuffed animal that stimulates make-believe would be credited. It may occasionally be more difficult to decide on this item when the key child is a boy, as families are often loath to provide their boys with anything that is "sissy." In such cases a cowboy suit or policeman's or fireman's hat would be acceptable. Cowboy boots would not.

31. Learning facilitators--mobile, table and chair, high chair, play pen. What is essential here is that the caregiver provide the child with a piece of equipment considered

necessary for various types of learning to occur, not just with a toy. (Mobile was included in order to have something applicable to very young infants.) The play pen may seem out of place in this item. It was included because it provides a safe environment in which an infant can play when the caregiver cannot provide direct supervision. In order for a play pen to be used for a positive score on this item, the caregiver should indicate that toys are placed in it whenever the baby is there.

32. Simple eye-hand coordination toys. This item involves such things as small objects that can be placed in and taken out of a receptacle, toys with more than one part that can easily fit together, large beads to string, etc. The items should be fairly small and should require precise hand movements--the child should not be able to move around and manipulate them at the same time.

33. Complex eye-hand coordination toys. Obviously this item is similar to the previous one, and Visitors will have to make an occasional judgment call as to whether a given coordination toy is "simple" or "complex." Both simple and complex manipulation toys often involve the combination of components. The key to the judgment of complexity is whether the combination that results from the child's manipulations can create an item that is more than and different from that created with repetitive combinations of

similar identical components. Thus beads to be strung (resulting in more beads on the string if successfully manipulated) is a simple eye-hand toy; so, too, are button/zipper/snap toys, snap beads, geometric shape sorters, ring cones, busy boxes, and cobbler benches. Lego blocks (which can result in shapes totally different from the shapes of the individual pieces) would be a complex eye-hand toy. Other examples of complex coordination toys would be nuts and bolts, Lincoln Logs, Tinker Toys, etc. In scoring this item, the Visitor must remember that what is crucial is not whether the infant/toddler uses a potentially complex toy in a mature fashion (e.g., tries to make a house with Legos) or uses it only in a somewhat pedestrian fashion (e.g., makes a "road" out of bricks all the same size). What is being measured is what the caregiver has provided, not what the child can do.

34. Toys for literature and music. This includes tapes, books, records, toy musical instruments, etc. Although the "literature" part (books, talking records) of this item seldom causes any trouble, the "music" part does. A record player that the child may manipulate would be a perfect example in that both story records and music records could be played on the instrument. Again consider the age of the child in scoring this item. For example, a rattle with a musical jingle would be acceptable for a baby but not for a

toddler. The radio is acceptable if the child is allowed to turn it on and select a station. The same would be true for a record player. If the family record player is accepted, then the child must be permitted to manipulate it. At least two such toys must be available (one for literature and one for music) in order for credit to be given on this item. Throughout items #30 - #34, the key to scoring is that the child be allowed to manipulate the play item even though he/she may not choose to do so. For example, the caregiver may report that she has bought blocks for her child but that the child never plays with them. In such instances, inquire in order to determine whether this is because the child is not interested or whether they have been kept from him or her. "Provides" requires that the child is not forbidden to touch, handle, or play with the item. The caregiver does not have to be the one who bought the items. What is critical is that the items be available to the child.

e. Involvement

This factor defines the extent to which the caregiver is actively involved in the child's learning and provides stimulation for increasingly mature behavior.

35. Caregiver keeps child in visual range, looks at often. This is an interview item pertaining to times when the caregiver and child are at home together. "Often" means frequently

enough to ensure safety of the child and to keep some kind of interpersonal contact going--the sort of thing lovers do when in the same room but out of reach of one another.

36. Caregiver "talks" to child while doing household work. "Talking" to the child in this item means that the caregiver in the course of her or his own work activities finds a way of including the child in what is going on. The caregiver may talk directly to the child, e.g., *"Well, I'm going to wash these dishes now"*; or *"It's time for me to wash the diapers."* Perhaps the caregiver may simply talk to the child as she goes about her work, *"I don't see how we can get a house so dirty."* The critical thing is that these comments occur within hearing range of the child or possibly with direct eye contact.

37. Caregiver consciously encourages developmental advance. The first key word in this item is "consciously," as it is indicative of a teaching attitude on the part of the caregiver. The second key word is "encourages." In order to encourage, the caregiver must do more than just "allow" the child to develop or a particular type of behavior to occur. Instead, the caregiver must take an active role (e.g., arrange the circumstances to assist development, praise the child's efforts, provide specific opportunities for behavior to be rehearsed). Credit on this item is given to the caregiver who finds little ways to help the child

learn to roll over, who occasionally puts a toy out of reach to encourage crawling, who gives the child a spoon to let her try to feed herself, who tries to teach patty-cake, etc.

38. Caregiver invests maturing toys with value via personal attention. Maturing toys are those which, the first time the child is introduced to them, call for abilities a little bit beyond any demonstrated to date. Thus they involve the acquisition of new skills and offer the child a challenge. Many times caregivers will present such toys, put them down in front of the child, and assume that the child should go on alone from there. Success on this item requires that the caregiver "talk up" the new toy, sit down and play with it herself or himself with pleasure and glee, or show the child how it can be used and encourage play with it. The encouragement should be participatory, not via some command like "*Go play with the fancy blocks I gave you.*"

39. Caregiver structures child's play periods. This does not mean that the caregiver must decide everything that the child should do throughout the day. Rather it refers to one who recognizes the short attention span of the young child and the need to offer occasional suggestions as to things the child might do. Structuring need not involve any request that the child play. For example, the caregiver who notices that her child is fretful, who then goes and gets a corn popper and puts it down in front of the child is

structuring the play period. Credit should also be given for a more verbal caregiver--i.e., one who says, "*Why don't you go and get your corn popper and play with it.*"

40. Caregiver provides toys that challenge child to develop new skills. Scoring this item requires some awareness on the part of the Visitor of toys that are and are not appropriate for children of a given age level. What is being assessed here is the caregiver's skill at estimating the child's ability and interest level and at finding materials that will challenge further development. Credit should be given even if the caregiver appears to overestimate the skills that the baby is ready to begin to acquire.

f. Variety

This factor encompasses the inclusion in daily life of people and events which bring some variety (without disorganization) into the child's life.

41. Mother provides some care daily. This is another item for which information will already have been provided during the session with the mother. On the original Inventory, the parent referred to in the item is the father. Presumably the item loaded on the Variety subscale because, in a home setting in which the mother is the primary caregiver, the father introduces some variety into the daily schedule. In at least some of the settings in which we use this version

of the Inventory, the father will be the one providing care. Accordingly, we need to know whether the mother provides some of the child's daily care during the hours that CHILD is in child care. In in-home care settings, use of the question as written will suffice. In care arrangements in someone else's home (family day care, relative care with or without pay, etc.), we would begin with the question, "*Who usually brings and picks up CHILD?*" If this is the mother, then obviously she provides some care. If not, then ask, "*Does the mother ever come to visit CHILD while he/she is in your care?*" If the caregiver says he/she doesn't know, then score negatively. Accept any other answer given and score accordingly. Do not count maternal care that occurs beyond the hours CHILD is in this child-care arrangement.

42. Caregiver reads stories to child at least three times weekly. This should refer to a children's book or magazine and, for toddlers, should be more than merely turning pages of a magazine and saying words. If the caregiver says, "I don't, but my husband or the older children do," score "+" if the designated reader is old enough to be a true reader.

43. Child eats at least one meal a day with caregiver and/or other children. The purpose of this item is to determine whether during mealtime the baby/child is in a social situation or is isolated. If the caregiver sits with the child but intently watches TV or talks to a neighbor, this

would not count as social interaction. A visitor is not likely to see this during a visit. If, however, the caregiver pays more attention to the TV than to the visitor during the interview, this is a pretty good indication that the same thing would occur at other times. Ask, "*How do you manage when one of your programs is on when you have to feed CHILD? Does he/she demand all of your attention? Or can you feed him/her and watch at the same time?*" For toddlers in family day care settings, a positive score requires that the children be fed with or near other children who are eating. It does not require that the caregiver sit down and eat with the children.

44. Caregiver and child visit or receive visits from neighbors or friends once a month or so. This item is self-explanatory. Does anyone come in to provide a bit of variety in the daily routine? Does the caregiver make the effort to extend the child's world by brief visits with other people? (In registered and/or licensed family day care, taking the child to some other home is not likely to happen. Any trips outside the home are likely to be of the field trip variety, which would be scored under 21.)

45. Child has 3 or more books of his own. If the setting is family day care, the books may be shared with the other children; they do not have to be identified as belonging exclusively to the index child. What is critical is that

they be accessible to the child. If the setting is in-home care without other children present (but with other children perhaps being present part of the time), the books should be identified as "BABY's books."

5. Specific Instructions for Observing and Interviewing

As stated in the previous section, we recommend flexibility in observing and interviewing during the home visit in order to obtain valid information about the child's current home environment. Real homes are alive and dynamic, and most caregivers are spontaneous and animated when they talk about children. In such instances you will get a better picture of the environment if you allow the caregiver to lead, accommodating information they provide to the wording of your items, and probe only when necessary. With other caregivers, of course, getting information is like pulling teeth. In such instances, you will need to check your interview prompts, note (if you have not already memorized it) the exact wording of the items, and make certain that you get all the needed information. Even in such homes, flexibility and informality on the part of the Visitor are needed to avoid an atmosphere which seems intrusive, formal, and businesslike.

a. Specific Instructions for the Observations

With the exception of Items 7 and 15, the first 18 items on the Infant/Toddler HOME are based entirely upon observation. Items 7, 15, 20-23, 35-39, and 41-45 depend largely on the interview. Items 19, 24, 26-34, and 45 can go either way. That is, observation may yield all the information necessary for scoring. However, if not, it is probably better to get the necessary information by interview on these items than to have the Visitor request to see a part of the house other than the area which the caregiver has set up for the visit. Item 40 is technically neither observational nor interview-dependent. It requires a judgment call based on what is seen and learned during the visit.

Even though the first third of the Child/Care HOME is based almost exclusively on observation, the Visitor should not expect to make the observations within the first third of the visit. In fact, none of the items can really be scored until the very end in that they pertain to behavior that might occur at any time during the visit or else to a specified number of occurrences over the entire observation period (e.g., praises child at least twice).

Essentially what you are observing is the nature of the interaction between the caregiver and the child. Even though the items are binary and sound very cut and dried, they manage to communicate the tone of the interaction: Is it warm and loving or distant and possibly hostile? Is there mutual pleasure in the relationship or annoyance and frustration? Are the needs of the child recognized and accepted, or are things run primarily on the caregiver's terms? These subtle manifestations of the nature of the home environment will indeed show up in the observation items.

Knowing the items in advance of the visit and being familiar with the exact cutting points chosen for the binary items (e.g., once, twice) will help the Visitor remain alert throughout the visit for the requisite number of occurrences. When you are finally completing the form it is crucial to **check and record** in case you need to "stage" something you might have forgotten (e.g., praising the child to note the caregiver's response) in order to be able to score all the observation items.

b. Specific instructions for the interview

The following interview schedule is to be used to obtain the necessary information to score all CC-HOME items not scored on the basis of observation.

1-6. Observation only.

7. *"Young children often put their hands in their food or in something else that's messy - like mud - and want to play with it. How do you handle it if he/she tries to do that?"*

8-10. Observation only.

11. This item (Caregiver responds positively to praise of child offered by visitor) does not require an interview probe. It is listed here merely to remind the visitor to be sure to offer praise in order to observe the caregiver's response.

15. "*Do you sometimes have trouble getting him/her to do what you want him/her to do?*" Wait for answer, then ask specifically, "*Have you ever had to spank him/her?*" If the answer is affirmative, ask, "*How often did you have to do that last week?*"

16-17. Observation only.

18. Do not ask if observable (availability of 10 books). If not, ask "*Do you find that you have time to do much reading?*" Wait for response, then ask, "*Do you have any books for yourself here in the house?*" If you don't get some number, then simply ask, "*Do you have as many as ten?*"

19. Observation generally. However, if none is observed, ask before scoring negatively, "*Do you have any pets?*"

20. "*I understand that you are the main person who cares for CHILD while his/her mother works. What happens if you are sick or have to be away from several hours or a whole day?*" Keep inquiring until you know whether there is a regular back-up system of not more than 2 other people. (Note: this item can actually be scored from the mother's report during the 15-month Home Visit if the caregiver does not know.)

21. *"Do you ever take CHILD (the children you care for) on little outings?"* If no, the scoring is obvious. If yes, ask for an example and then ask about how often he/she does this.

33. *"Do you take CHILD (the children) outside very often?"* Follow-up on whatever he/she says to determine whether this occurs at least four times a week.

23. *"What would you do if you had an emergency with CHILD?"* If the response does not include information that the plan (phone numbers, contact people, etc.) is written down somewhere, ask, *"Do you have to remember all of this, or do you have it written down somewhere?"* If you doubt caregiver's veracity, ask to see the list.

24-35. Observation. If this is a family day care home, the interview will most likely take place in the room in which most of the care is provided and will contain the accessible toys. If it takes place in a living room, you may have to inquire. If so, ask a general question, *"Tell me about the toys you have for CHILD to play with."* Check off types as mentioned, but do not assume that failure to mention means unavailability. If necessary, ask about each type, using essentially the wording on the scoring form.

36. *"What do you do with CHILD (The children) while you take care of some of the other things you have to do each day?"* (Be careful not to suggest the scorable answer with your questions.) *"Do you put him/her in his/her (crib, play pen) while you get the*

lunch (straighten the room, clean the bathroom, etc.)?" Then, if necessary, try, *"Do you keep him/her in the room with you when you do those things?" "Is he/she interested in what you are doing?"*

37. *"Have you tried to teach CHILD any little games like ring-around-a-rosie?"*

38. *"Is CHILD interested in the toys you have for him/her?"* Whatever the answer, ask, *"How do you get him/her to play with the toys?"*

39. *"Children this young often can't pay attention to anything very long. What do you do if he/she seems restless or bored?"*

40. Observation. Make your own judgment here.

41. If this is family day care, ask, *"Who usually brings and picks up CHILD?"* If "His/her mother" is not the answer, ask, *"Do you know whether CHILD's mother takes care of him/her part of the time every day?"* See the manual for details on this item.

42. *"CHILD's pretty young for books, I suppose. Do you ever read little books to him/her?"* If the answer is affirmative, ask, *"About how often do you do that?"*

43. *"How do you handle mealtime with CHILD?"* (Check the manual for possibly necessary probes on this item.)

44. *"Do any of your neighbors come over and visit while you are caring for CHILD?"* Wait for answer, then ask, *"About how often does that happen?"*

45. Observation is usually sufficient. If necessary, ask, "*Are there any books here that CHILD can look at or try to hold?*" If this is a family day-care setting where other children are also present, books that are accessible to the children count; they do not have to belong exclusively to the target child. In a home setting without other children, they should "belong" to the child.

IV. PROBLEM SOLVING FOR THE ENTIRE VISIT

Here are some of the problems we have anticipated with suggested actions.

- The child is absent. Try to find out why the child is not present. If the child is sick, call the parent to find out when the child will be back so that you can reschedule your observation within the allotted window.

- The child goes to the bathroom (older children) during observation period. Stop the tape. Once the child returns to the room, begin the observation again. Do not stop for a diaper change.

- The children go for a walk, to the store, etc. Continue observation.

- A crisis arises during your visit and the caregiver asks you to babysit. You are not a babysitter and cannot be responsible for looking after the children in her care during her absence. He/she should make whatever arrangement he/she would have if you were not there. (However, when a conflict between scientific and ethical principles arises, be ethical, be humane, use common sense and good judgment, call your PI or PC.)

- A child is in danger and the caregiver is busy elsewhere. Do not let an accident happen while you stand by. Alert the caregiver or intervene.

- The child lies down for nap or goes to sleep.

  - during the first observation cycle on Day 1. If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes, then do the Profile observation. Ask the caregiver if the child is likely to awaken in the next hour or so. If this is likely, you may want to wait to do another observation cycle; if you do not want to wait, give the caregiver(s) the questionnaires, schedule a second visit and leave. You will have to do 3 observation cycles on Day 2.

  - during the second observation cycle on Day 1. If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes, then do the Profile observation. Give the caregiver(s) the questionnaires, schedule a second visit and leave. You should do 3 observation cycles on Day 2. Mail all cycles, whether completed or not, to the DCC.

  - during the third observation cycle on Day 1. This was your insurance cycle. If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes, then do the Profile observation. Give the caregiver(s) the questionnaires, schedule a second visit and leave. You will need to do 2 cycles on Day 2.

♦ during the first observation cycle on Day 2. If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes. Ask the caregiver if the child is likely to awaken in the next half hour. If this is likely and you only did 2 observation cycles on Day 1, you may want to wait to do another observation cycle; otherwise, you will need to schedule a third visit (although try to avoid having to schedule a third visit). Do not do the interviews until you have (at least) 4 observation cycles complete.

♦ during the second observation cycle on Day 2. If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes. Then proceed with the interviews.

♦ The child becomes aware that you are observing her/him. Stop the audiotape and turn your attention to another part of the room. After 2 minutes resume your observation. Do this only once. After that avoid eye contact. Look away, at your papers, the wall, another child, or the caregiver (and code child's activity as "unoccupied/watching" if child continues looking at you.)

♦ The target child or another child persists in interacting with you. Attend to the child briefly by telling her/him that you have to work. You can begin writing or redirect your attention elsewhere. If you were sitting, try standing up to do the observation. If you were located in the midst of the children's activity, try moving to another position.

♦ The caregiver leaves or goes on break in middle of observation. Go on observing. When the observation is complete, if the caregiver is just on break, you can do the interview during or after the break. If the caregiver has left the premises you can do the interview over the phone. (It will be important to know the schedule of the primary caregiver, especially when he/she usually leaves, before you schedule your visit, so as to avoid these situations.)

♦ The caregiver refuses to participate in the study. First, try to ascertain why the caregiver has concerns. If possible, try to answer the questions that he/she has. Explain the importance of her/his contribution. However, if the caregiver still refuses there is not much else you can do.

♦ The caregiver attempts to engage you in conversation during the observation. Let her/him know that you do want to talk, but that you have to time the observation. Tell her that you will have an opportunity to talk at the end of the observation (in about x minutes, or on your next visit).

♦ The mother shows up while you are observing. Stop the observation and wait till she has gone to start it again. Perhaps you could do the Profile observation in the meantime.

♦ The caregiver asks you what you are observing. Only general information should be given to caregivers and should be specific to questions actually asked. Emphasis should be on our wish to capture the child's experience in the setting and not on any desire to evaluate the quality or adequacy of the center, home, or caregiver. Emphasis should be on the "exploratory" (vs. evaluative) nature of the data collection: We don't know how children's experiences contribute to their development unless and until we collect information about those experiences.

♦ The parent asks for information about the child care setting. Most times the person talking to the parents will not have any information about the child care setting because a different observer will be making these visits. Parents who ask, however, should be encouraged to observe in their own daycare sites, to talk to their caregivers about their concerns, etc. They should also be told that decisions about day care arrangements are personal ones, and that what makes one parent comfortable will not necessarily make another parent happy; hence our advice is not as important as the parents' personal observations and values. You could also say that the caregiver has signed a consent form assuring her that the information you collect will be confidential.

♦The care you are observing is suboptimal. It is our responsibility to report any clear cases of abuse or neglect (see Manual for 1-month visit for details). If care is not truly abusive or neglectful, however, although it may be chaotic, inattentive, noisy, or bleak, it is not appropriate for the observer to intervene or to report the inadequacy of the care to the parent. To do so would jeopardize our opportunity to gather data on less than ideal day care. Potentially life-threatening or injurious, but not abusive, practices (e.g., open fire, open stairway, open window, small toy parts available to children, etc.) should be brought to the attention of the caregiver(s)/director and to your PC and PI. If not remedied it may be appropriate to bring it to the attention of the parents.

♦ The caregiver asks for information about child care, the child, child abuse, etc. Tell the caregiver you need to check with the PI/PC, and then together you can come up with some reasonable and specific answer. It has been suggested that we put together a packet of resources for caregivers, but I think we should just have such a packet on the PC's desk and draw from it selectively and only as requested/required.

V. OVERVIEW FOR SEASONED OBSERVERS

The same procedures will be followed at 24 months as at 6 and 15 months for recruitment, obtaining consent, order of procedures, number of visits, number of observation cycles, ORCE coding, administration of observations, interviews and questionnaires, and training and reliability (except, of course, the details of time and place for the last). Note, however, that many of the assessment instruments have changed, some in minor ways and some in major ways.

Timing of visits. The first child care visit should occur after the home visit and within the period between the child's 24th- and 26th-month birthdays. The second windows visit should occur as close as possible to the 1st and definitely not on or after the child's 29-month birthday. No arrangement or classroom should be visited until the child has been enrolled for at least 2 weeks. Child care assessments should be made within 1 month of the 24-month home visit, preferably within 2 weeks.

Child Care Provider Packet. Four of the questionnaires are the same as those used at 15 months: "When Parent Leaves/Returns" (McCartney Pick Up/Drop Off), "Ideas about Raising Children" (Schaefer Modernity), and "Taking Care of Young Children" (Marshall Caregiver Stress), and "My Feelings". Two new questionnaires have been added: "Child Behavior Checklist (Achenbach) and Social Behavior Inventory (Scott and Hogan).

Profile. The profile has been adapted for older children.

Home. The HOME is the same.

ORCE. The ORCE procedure is the same; however, there are new definitions for some items and some new categories.

New Qualitative Scales. These scales have been revised so as to be developmentally appropriate for 24 month olds.

INTERVIEWS. In general, the interviews at 24 months are the same as those used earlier.

VI. CHILD CARE ASSESSMENTS AT A GLANCE

In a center:

A. Recruit the director and do director telephone interview.
B. Send information confirmation letter, and Director Questionnaire
C. Confirm visit the day before the scheduled visit.
D. Call the morning of the visit to ensure the child is present
E. Do first visit:
   1. See director, get/go over Director Questionnaire/consent forms
   2. 2 ORCE cycles
   3. Profile observation items
   4. Child care provider packet
F. Do second visit:
   1. 2 ORCE cycle (or 2)
   2. Profile interview with caregiver 1
   3. Caregiver interview with caregiver 1
   4. Caregiver interview with caregiver 2
   5. Pick up child care provider packet

In a daycare home or Child's home:

A. Recruit provider
B. Send information and confirmation letter
C. Confirm visit the day before the scheduled visit
D. Call the morning of the visit to ensure the child is present.
E. Do first visit:
    1. Warm-up chat + consent form(s)
    2. 2 ORCE cycles
    3. Profile-observation items
    4. HOME - observation items
    5. Leave child care provider packet
F. Do second visit:
    1. 2 ORCE cycle
    2. HOME interview
    3. Profile interview
    4. Caregiver interview(s)
    5. Pick up child care provider packet

VII. APPENDICES

A. Recruitment Letter for Child-care providers

Dear

As you may already know, (child's name) is taking part in an exciting and important study -- the National Institute of Child Health and Development Study of Early Child Care. He/she has been in the study since he/she was born.

The study aims to learn how the different people, places and events in the lives of young children affect their development. Enclosed is a brief description of the study that tells you more about it.

Because child care provided by adults other than parents is such an important part of children's early experiences these days, we would like to see (child's name) in his/her child care setting. We would like to come and see (child's name) when he/she is with you. His/her parent(s) have given their permission.

We know you are busy, but we would not disrupt your routine and we would try to work around your schedule. You would not need to do anything special because we were there. We want to see what (child's name) is usually like when he/she is with you. One of our staff would just watch (child's name) doing whatever he/she typically does and ask you some questions about his/her activities and about your background and experiences. Some of these questions can be answered during the visit; others would be answered on a form that he/she would leave for you to fill out.

Your participation in the study will provide valuable information which will help all of us learn more about young children's development.

In appreciation of your help we will pay you $40.

We will be calling you to tell you more and to answer any questions that you may have about the study. If you want to call us in the meantime, the number is.....

B. Confirmation Letter to Home Care Provider

Dear

Thank you for agreeing to participate in the National Institute of Child Health and Development Study of Early Child Care. It is very important for us to be able to observe (TARGET CHILD) while in your care. Your willingness to let us visit will help us understand how both family care and child care can affect children's development.

As we discussed on the phone, we have scheduled the first of our two visits on __________________________ from ______ to ________ (approximately). The second visit will be on _____________ from ___________ to _________ (approximately). With this letter, we have enclosed a brief description of the study and our visits [FOR SITES THAT NEED TO SEND CONSENT FORM IN ADVANCE: and a copy of the consent form (we will bring an extra when we come)]. When we come for the visit, we will ask you to sign a consent form, assuring you of the confidentiality of our observations.

Once the visits are completed and you send in a questionnaire, we will make you a gift of $40, in appreciation of your time, and, if you are interested, we will send you a report of the findings when the study is completed.

I will call you the day before the first visit to confirm the visit. Please call us if you have any questions before then (phone number).

Yours sincerely
Staff Member
Project Coordinator
Project Director

C. Confirmation Letter to Center Director

Dear

Thank you for agreeing to participate in the National Institute of Child Health and Development Study of Early Child Care. It is very important for us to be able to observe (TARGET CHILD) while in your care. Your willingness to let us visit will help us understand how both family care and child care can affect children's development.

As we discussed on the phone, we have scheduled the first of our two visits on __________________________ from ______ to ________ (approximately). The second visit will be on _____________ from ____________ to _________ (approximately). Please talk to the caregivers who take care of (TARGET CHILD) before we come to visit. This is very important.

With this letter, we have enclosed (1) a brief description of the study and our visits (for you to post if you wish) and (2) a questionnaire that we would like you to fill out [FOR SITES THAT NEED TO SEND CONSENT FORM IN ADVANCE: and (3) a copy of the consent form (we will bring an extra when we come)]. When we come for the visit, before we begin our observation, we will ask you and the staff who participate to sign a consent form, assuring you of the confidentiality of our observations.

Once the visits are completed we will make a gift of $40 to the center, in appreciation of your time, and, if you are interested, we will send you a report of the findings when the study is completed.

I will call you the day before the visit to ask you some questions about your program. This will save time during the actual visit. Please call us if you have any questions before then (phone number).

Yours sincerely
Staff Member
Project Coordinator
Project Director

D. Description of Study

Children born today will be growing up in a world different from that of their parents. How will growing up in the 1990's affect children's development? To answer this most important question for American's future, the National Institute of Child Health and Human Development has funded the Study of Early Child Care.

The Study of Early Child Care is being conducted at ten different sites in the United States. The main aim of the study is to learn about the variety of people, places, and events that children experience in their early years and the many pathways that lead to healthy development. Aspects of development that are being studied include social relationships, language, intellectual abilities, and health.

Families become involved in the study on a voluntary basis soon after the child's birth. Several times during the three years that the families are involved in the study, the children and their parents are observed and interviewed. Parents are asked to describe their views about child rearing, their feelings about working and parenting, and their perceptions of the child's personality and behavior. Because child care outside the family is also an extremely important setting in which children grow and change, caregivers are asked to participate as well.

Each child in the study is visited in his or her care setting on one or two days, when he or she is 6, 15, 24, and 36 months of age.

During the visits, a staff member observes the child for about 3 hours. He/she tries not to interfere with the usual routine in the child's room. Then, he/she talks to the caregiver(s) briefly about the child's activities and about the caregiver's education and experience. This takes less than an hour 20 minutes of the caregiver's time, and the staff member works around her schedule. At the end of the visit, he/she leaves some questionnaires for the child's caregiver(s) to fill out. These questionnaires contain questions about the child and about the caregiver's views on child care.

Because we want to see what usually happens when children are in child care, we try to make our visits interfere as little as possible with the caregiver's routine.

The results of this study will not only guide policy makers, but will also be of more immediate use to parents and child-care providers as they engage in the rewarding, but challenging, responsibility of rearing young children.

E. Consent Form

Children born today will be growing up in a world different from that of their parents. How will growing up in the 1990's affect children's development? To answer this most important question for America's future, the National Institute of Child Health and Human Development has funded the Study of Early Child Care.

The University of California - Irvine, is one of 10 sites across the country conducting this study. The purpose of the study is to learn about the variety of people, places, and events that children experience in their early years and how these relate to their development. Children are observed periodically from the time they are one month old until they are 3 years old. Their parents are interviewed about the children's experiences at home and in other settings.

You are caring for one of the children, (name), who is participating in the study. We wish to observe the child while he or she is with you. The child's parent(s) have consented to this visit.

We will try not to interfere too much with your routine. A staff member will come to watch the child's activities for about three hours, on each of two different days. You do not need to do anything differently for the visits. We want to see what usually happens when the child is with you. We want to see the CHILD's typical day -- what he/she does, who he/she plays with, how he/she acts with you. We will also talk to you about the child's activities and your experiences in looking after children. He/she will ask you some questions about your education and goals. Some of these interviews may be tape recorded. The staff member will also have you fill out forms asking about the infant and about your experiences and your views on childrearing.

Our visit with you will help everyone understand how both care at home and in child care can lead to healthy development.

At the end of our two visits you or your center will be paid $40 in appreciation for your time.

Your identity will, of course, be kept completely confidential. All of the data we collect will be given a code number and will not be identified by name. Access to the data will be restricted to people who work on the project. We will not be sharing the observations made in your center or home with [the child's] parents. The information we obtain will not be used for any purpose other than research.

You may withdraw your consent for the observation and you may refuse to answer any questions at any time without penalty. [We do not expect that it will ever happen, but we are required by law to report any incidents of serious abuse or neglect that we observe. THIS STATEMENT MAY NOT BE REQUIRED AT ALL SITES -- CHECK]

Signing this form indicates that the study described above has been explained to you, and that you voluntarily consent to participate. It also indicates that you have had an opportunity to ask questions and understand that future questions you may have about the research or about your rights as a participant in the study will be answered by one of the investigators.

____

Director/Care provider

____

Teacher/caregiver

____

Teacher/caregiver

____

Research staff member

____

Date

F. Materials Required for Child Care Assessments

The materials required for a child care assessment vary, depending upon whether the provider is a center-based provider, a family day care home-based provider, a babysitter, or a relative.

The child care visit checklist will help you determine which materials to bring to which type of visit. You may want to keep these worksheets on file at your site in order to have a record of when materials were submitted to your PC.

CHILD CARE VISIT CHECKLIST

CHILD ID________________________ RA ID____________________

	DATE COMPLETED	DATE TURNED IN TO PC
CONSENT FORMS (CAREGIVERS, DIRECTOR)		
ORCE ROUND 1		
ORCE ROUND 2		
ORCE ROUND 3		
ORCE ROUND 4		
ORCE ROUND 5		
PROFILE (CENTER / FDC)		
HOME (FDC ONLY)		
DIRECTOR QUESTIONNAIRES (CENTERS ONLY)		
CAREGIVER INTERVIEW 1 (CENTER / FDC / FATHER)		
CAREGIVER INTERVIEW 2 (IF 2ND PROVIDER)		
CHILD CARE PROVIDER PACKET 1		
CHILD CARE PROVIDER PACKET 2 (IF 2ND PROVIDER)		
CBCL		
ASBI		
POST VISIT INTERVIEW AND RATINGS OF THE CAREGIVING ENVIRONMENT		
PAYMENT / RECEIPT		

G. Observation Schedule Face Sheet

OBSERVATION SCHEDULE FACE SHEET

CHILD ID #:____________________

CHILD NAME:____________________

DATE OF BIRTH:____________________

MOTHER'S NAME:____________________

FATHER'S NAME:____________________

HOME PHONE #:____________________

HOME ADDRESS:____________________

____

INTERVIEWER:____________________

DATE OF INTERVIEW:____________________

INTERVIEW WINDOW:____________________

ASSESS. WINDOW:____________________

COMBINED WINDOW:____________________

CHILD CARE ARRANGEMENT TO BE VISITED

NAME OF PROVIDER:____________________

NAME OF DIRECTOR (IF CENTER):____________________

NAME OF PROGRAM:____________________

ADDRESS:____________________

____

PHONE:____________________

DAYS / HOURS:____________________

DATE ARRANGEMENT STARTED:____________________

PROVIDER'S RELATIONSHIP TO BABY:____________________

# OF OTHER CHILDREN PRESENT:____________________

______BABY'S HOME ______SOMEONE ELSE'S HOME ______CENTER

CHILD CARE RA:____________________

VISIT ONE DATE:____________________

VISIT TWO DATE:____________________

DIRECTOR INTERVIEW:____________________

CHILD CARE RA ID:____________________

TIME OF VISIT ONE:____________________

TIME OF VISIT TWO:____________________

CONFIRMATION LETTER:____________________

(INCLUDE DIRECTOR QUESTIONNAIRE IF CENTER)

NOTES:

H. Child Care ID Worksheet (NOT to be sent to the DCC)

Child Care ID Worksheet

Observation Cycle #

Behavior Scales	Temporary ID*	Final ID Description**	REL	ASSIGN	QUALS?***	END OF VISIT	INT/QUES?
Caregiver 1							
Caregiver 2							
Caregiver 3							
Caregiver 4							
Caregiver 5							
Caregiver 6							
Caregiver 7							
Caregiver 8							

Observation Cycle #

Behavior Scales	Temporary ID*	Final ID Description**	REL	ASSIGN	QUALS?***	END OF VISIT	INT/QUES?
Caregiver 1							
Caregiver 2							
Caregiver 3							
Caregiver 4							
Caregiver 5							
Caregiver 6							
Caregiver 7							
Caregiver 8							

Observation Cycle #

Behavior Scales	Temporary ID*	Final ID Description**	REL	ASSIGN	QUALS?***	END OF VISIT	INT/QUES?
Caregiver 1							
Caregiver 2							
Caregiver 3							
Caregiver 4							
Caregiver 5							
Caregiver 6							
Caregiver 7							
Caregiver 8							

rvation Cycle #								
Behavior Scales	Temporary ID*	Final ID Description**	REL	ASSIGN	QUALS?***	END OF VISIT	INT/QUES?
Caregiver 1							
Caregiver 2							
Caregiver 3							
Caregiver 4							
Caregiver 5							
Caregiver 6							
Caregiver 7							
Caregiver 8							
Observation Cycle #							
Behavior Scales	Temporary ID*	Final ID Description**	REL	ASSIGN	QUALS?***	END OF VISIT	INT/QUES?
Caregiver 1							
Caregiver 2							
Caregiver 3							
Caregiver 4							
giver 5							
regiver 6							
Caregiver 7							
Caregiver 8							

*Use A,B,C,D, etc.

**Use first name, appearance, etc. to assure you will keep this person consistently identified across observation cycles and days.

***Indicate whether the person is Caregiver 1, 2, or 3 for the Qualitative ratings conducted after each Behavioral rating cycle. If not considered in Qualitative ratings, leave blank.

BEST COPY AVAILABLE

I. CONFIDENTIAL WORKSHEET for Assigning Final Child Care IDs (not to be sent to Data Center)

Use this sheet to record final ID's and match them with actual programs and providers. This must never be sent to the Data Center and should be kept in the child's locked data file under the 24 month child care visit at all times, for completion and reference only by the PIs, Site Coordinators, and designated personnel.

In the case of center-based programs, record the name and ID of the director, and then record the names and IDs of all providers observed in this center. For all other arrangements, only names or providers will be recorded. This is the only way we will know when multiple providers were seen in a single arrangement.

When the same provider/center is used by more than one study child, USE THE SAME FINAL ID NUMBERS.

CONFIDENTIAL WORKSHEET CAREGIVER ID'S

Date ____________________

Child ID ________________

Name of Director ____________________	Temp. ID	Perm. ID
Name of Center ____________________	________	________
Name(s) of Provider(s) ____________________	________	________
____________________	________	________
____________________	________	________
____________________	________	________
____________________	________	________
____________________	________	________

J. Training and Reliability for Live Ratings

Becoming reliable on the qualitative and behavioral ratings, and on the Profile and the Child Care HOME, requires that observers (a) be extremely knowledgeable of the coding manuals, (b) apply this knowledge to the task of watching children and caregivers, and of rating environmental quality, and (c) use the same metric in their assignment of ratings as that used at the other nine sites.

The task of creating reliable raters across 10 sites as part of a longitudinal study is formidable. The successful implementation of the qualitative and behavioral scales is dependent upon observers in all the sites using the same "cut" points when they make their ratings. Similarly, it is crucial that observers code the Profile and Child Care HOME comparably.

But, there are many difficulties. Not all observers will be able to attend the live training. A method of training these people had to be found. Another difficulty is that consistency in ratings must be maintained over a 10-month period. Observer and site drift must be minimized. Also, because new observers may be joining sites as the study progresses, a way had to be found to insure that these new observers are trained in precisely the same way as previous observers. A final difficulty in this 10-site collaboration is that child care quality may vary systematically across sites, resulting in a different internalized metric at different sites.

For each of these reasons, we adopted a strategy of using comprehensive training films with accompanying text that can be used and studied at each site for the qualitative and behavioral ratings. The Profile and Child Care HOME measures cannot be captured on video, and require somewhat different training and reliability procedures, as described below.

1. Preparation of Training Tapes for the ORCE

An important component of training is for coders to experience the full range of child care settings and experiences. Therefore, videotapes of infants in day care centers, family day homes, nanny care, father care, and grandmother care were collected. Children were videotaped during feedings, diapering, play periods, and when they were left unsupervised. Children were also taped in child care situations that varied widely in quality. Diversity in terms of the children's and caregivers' ethnicity, race, social class, and geographic region was important. From this video library composed of many hours of tape representing ten sites in the network, training films for the qualitative and behavioral ratings were created. These films were created in order to expose coders to the greatest diversity in child care experiences within a reasonable period of time.

2. Training Procedures for the Qualitative and Behavioral Ratings

a. Qualitative Ratings

Training on the qualitative ratings goes through a progression of steps designed to prepare observers incrementally for their task.

Step 1 - Prior to beginning formal training coders are expected to be extremely knowledgeable of the coding manual. They should be able to define and know the four points of each qualitative scale. They should also be able to supply illustrative examples of each concept. Trainees should be able to pass a written test demonstrating their knowledge of all qualitative items.

Step 2 - The next step of training is to illustrate via multiple taped snippets taken from diverse child care settings what is meant by each item on the scale. To this end, for the qualitative rating scale, there is a ONE-HOUR VIDEOTAPE illustrating both the positive and negative end of each scale. For example, this tape shows several instances of what we mean by caregiver sensitivity to distress, as well as, several instances of caregiver insensitivity. Multiple exemplars of caregiver positive and negative regard, stimulation of development, and each of the other scales are also provided. Written text describing each snippet and coding decisions relevant to the snippet are to be provided during training.

Step 3 - The third step of the training consists of learning the cut points for the scales (2-hour training module). This session has trainees view ten 10-minute videotaped segments selected to expose trainees to a wide variety of child care settings. All of the trainees can view a video segment simultaneously, but they are instructed not to make comments to each other. They are to make written notes as they view the segment. After viewing each segment, trainees independently rate the segment using the qualitative rating scales. Their rating for each scale is noted. Feedback as to the accuracy of the segment ratings, in comparison to the master ratings, is then given. Part of this feedback consists of presenting and reviewing written justifications for each scale, i.e., why we assigned the rating that we did. When the feedback from one segment is completed, trainees then move on to the next 10-minute segment and go through the same process. Because these segments are supposed to familiarize the trainees with decision rules and cut points, high reliability may not be achieved on the scales, particularly in the first of the tapes being reviewed.

Step 4 - The next four hours of training (divided into two 2-hour sessions) enable the trainees to practice making ratings over 44-minute periods, the actual duration of their observations in the field.

Step 5 - Once they return to their sites, trainees should re-play each training tape to practice completing the behavioral and qualitative scales. During practice, trainees assessments should be done independently, with trainees comparing their ratings and scores with the master ratings only after they made their own independent judgements. Trainees should carefully study the written justifications and explanations provided for each training tape.

Step 6 - Trainees should then practice doing "live" behavioral and qualitative ratings at their home site using a variety (types and qualities) of child care settings. Ideally pairs of observers will make observations that they can compare at the end of 44 minute periods. A minimum of one visit per week should be completed during this practice period. Questions regarding these scales or coding decisions should be directed to Kathleen McCartney (behavior scales) or Jay Belsky (Qualitative scales).

b. Behavior Scales

Step 1 - Before the training, designated trainees from each site will have memorized coding rules and definitions. Each site director is responsible for assuring that his or her trainees have memorized the manual prior to the training. Trainees should be prepared to pass a written test demonstrating their knowledge of the code when they come to the training.

Step 2 - The third step of the training for the behavioral code consists of learning to identify relevant behaviors, (2 hour training module). This session has trainees view the same 10-minute videotaped segments used for the qualitative ratings. In this case, however, trainees will observe for behavior frequencies in 30 second intervals. The tape will be stopped and they will mark independently all relevant categories. Immediate feedback on a frame-by-frame basis will be given. After several tapes are scored in this way, trainees will watch and score entire 10-minute segments using the behavior scales. Agreement with the master coders will be determined after the whole segment is scored.

Step 3 - The next four hours of training (divided into two 2 hour sessions) enable the trainees to practice making observations over 44-minute periods, the actual duration of their observation cycles in the field. For this part of the training, trainees will complete the behavior scales for 30 minutes. They will observe and make notes for the qualitative ratings for 10 minutes. Qualitative ratings will then be made on a full 44-minute segment. Once again, verbal and written feedback in the form of the master coding decisions will be provided for each segment prior to moving to the next segment.

Step 4 - During the next part of the training observers are expected to review all of the training tapes and documentation. Then they are to practice doing "live" observations at their home site using a variety of child care settings.

3. Training Procedures for the Child Care HOME

Judith Brisby, from the Arkansas site will conduct the training on the Child Care HOME. Three videotaped HOME interviews will be observed. The first tape will be used to define all items. The second and third tapes will be coded independently by each trainee and then compared to a criterion code from the Arkansas site. Finally, role playing will be used to provide practice on phrasing questions to obtain the necessary data.

4. Training Procedures for the Profile

Because the Profile is designed to capture the quality of the child's child care environment -- comprehensively defined -- videotapes do not lend themselves as the best method of training. Deborah Phillips will provide the training. In addition, one observer from each site will visit two infant child care programs, over two days, as a member of a pair, to practice coding the Profile in a live situation. These pairs of coders will compare notes and any questions that arise will be discussed with observers who are reliable Profile coders (trained to reliability by A. Sibley). No inter-observer reliabilities will be obtained on this measures during the training.

5. Some Words About Getting Used to Being an Observer

There's no question: being an observer is a unique and often frustrating experience. At first, you feel frustrated because there are so many things happening and you have to figure out how to categorize and code them in a limited amount of time. But even after you have the coding system down pat, there will be frustrations because events will occur that you feel the coding system is not adequately capturing. Resign yourself to this fact. You are an imperfect recorder and the observation system is incomplete. We hope, though, that aggregated across different observation cycles, on different days, and with different children, the records you make will lead to a meaningful "big picture".

Another frustration is feeling that what you are observing is not representative of what usually goes on in the setting. It's an atypical day, or your behavior is influencing the caregiver's or the child's behavior. Again, resign yourself to this limitation of doing in-person observations. There undoubtedly are differences because of your presence. But if you are unobtrusive, inconspicuous, and unthreatening, it is possible for caregivers to relax and children to ignore you and go about their normal routines. Caregivers will probably try to be on their "best behavior" (children won't care), but even if they are, their "best behavior" will be revealing of their typical behavior and will discriminate among individuals. As Frederick

Wiseman (documentary film maker extraordinaire) pointed out, when people know they are being filmed (or observed), they tend to behave in the ways they know best and feel most comfortable with, not in ways that are novel and unfamiliar. Atypical events and "bad days" will be hidden in the aggregation of data across cycles, days, and children.

You may also feel frustrated because you are doing the same thing over and over again (the same coding every minute; the same set of cycles and procedures). Avoid this frustration -- a kind of burnout -- by taking an interest in the overall events occurring in the setting, not just focussing on the minute-to-minute coding. Think about the "big picture" of day care quality. Look for unusual occurrences. Take an interest in individual children and caregivers. If you feel you are simply on automatic pilot, discuss this with your project coordinator. You may need a break or some more variety in your work.

Finally, you may feel frustrated because your role as an observer precludes normal interaction with the caregiver or the children during the observation. As an observer, you may look but not touch. At times, this may feel strange, strained, uncomfortable. You may feel that you are acting weird. This is something you'll have to get used to. Try to distance yourself from the ongoing events as if you are watching a movie -- just make sure it's a really interesting movie.

6. Becoming Reliable with the ORCE, Profile, and Child Care HOME

a. ORCE

Three times during each data collection period, criterion videotapes will be independently coded by observers at each site using the ORCE. For the 24 month visits these tests will be November 20, 1992; April 20, 1993; August 20, 1993. Upon completion of their assessment, observers will send their rating sheets to the Data Center where inter-observer reliability will be calculated. The Data Center will compare individual observers' ratings for each scale against those for master coded tapes. The criterion tapes for the Qualitative Ratings are to be scored by Margaret Owen (WI), Jay Belsky (PN), Deborah Vandell (WI) and Anne Stright (WI). Criterion tapes for the behavior scales are to be scored by Nancy Keefe (UNH), Kathy Masters (UCI) Alison Clarke-Stewart (U.C.) and Kathleen McCartney (UNH).

In general, when coding from videotapes for the reliability tests, do not code anything you cannot see. Do not infer anything. For example, if a caregiver is smiling but you cannot see if the child is smiling, do not code shared positive affect. (Presumably if you were there, you could move to get a better view.) If the caregiver is off-screen and you can tell that she is talking to the target child, code this (but only if it is obvious.)

If a trainee fails to reach criterion on either the qualitative or behavior scales, the principal investigator and site coordinator for that site will be informed. Feedback as to problem areas will be provided. The trainee then has several weeks to study and prepare for a make-up test. If this second test fails to reach criterion, the observer will not be allowed to make qualitative or behavior ratings.

In addition, at every site, regular "live" reliability assessments should be conducted. Two observers will conduct periodic child-care visits together (these may be for real subjects or for non-subjects). Spread these visits evenly across the 24 month data collection period. They will go together to the second of the pair of child care visits and complete two ORCE observation cycles, the Profile, End of Visit Scales, and the HOME. They may compare their scores (a valuable source of continued training) - but not change them. Both observers' score sheets are then sent to the Data Center so that live reliability scores can be computed from them. For data analyses, the "official" data for a given child are the scores submitted by the child's primary observer (the individual who made the first of the pair of visits). If the subject being rated is NOT a regular study subject this fact must be noted and an ID number assigned using an 8 in the second digit as the ID in place of the hospital code and the last three numbers assigned from a new set of numbers starting with 001.

For sites with two or three raters: The basic principle is that each observer must be paired an equal number of times with the other observer(s) and must be balanced across types of care (center and family). Therefore for two observers the two will rate together in three center based and three family based situations. The center based and family based situations should be alternated. For two raters there will be a total of six pairs of joint ratings.

For sites with three raters each of the pairs (A-B, A-C, and B-C) will rate together in each of two center based sites and two family based sites. (A total of 12 sites will be used; each observer will participate in 8 reliability observations.) Within pairs there should be an alternation of center and family sites.

The order in which pairing should rate is more flexible, but it would be preferred that there be a randomization of pairings over the time period. A typical arrangement would be

AB Center	Rating Time 1
AC Center	Rating Time 2
BC Center	Rating Time 3
AB Family	Rating Time 4
AC Family	Rating time 5
BC Family	Rating time 6
etc.	

b. Profile and End of Visit Scales

For these measures, only inter-observer, intra-site reliability will be assessed.

c. HOME

H.O.M.E. Certification Procedures

24 Month Assessment Period

The certification process for the H.O.M.E. will begin with child care observers studying the manual, newsletters, H.O.M.E. updates and training tapes.

A. Initial Certification:

There are three criteria which must be met for initial certification to be achieved. They are:

1. Self Administration Video Tape - each child care observer will administer the child care H.O.M.E. in a child care setting. This entire administration of the 24 month child care H.O.M.E. will be video taped. (This may be done on a pilot or volunteer and need not include the other child care procedures.) This video tape will then be scored by the child care observer. Scoring should be based exclusively on what is obtained from the video tape, not on observations made during the visit that are not recorded on the tape. Each item on the score sheet should be scored "yes" or "no". A reliability score of 90% or greater with a master coder from the Arkansas site must be achieved in order to pass this portion of initial certification.

2. Reliability Test - a certification reliability video tape will be provided by the Arkansas site. Criterion scoring has been developed for each item based on information contained in the video tape. All items will be marked "yes" or "no". In order to be certified, a child care observer must be in agreement with criterion scoring on 41 of 45 items.

3. Interviewer Monitoring Form - this form is a checklist of observer behaviors to be reviewed in making an overall appraisal of the manner in which s/he administered the child care H.O.M.E. This form is completed by the master scorer when reviewing a child care observer's self-administration video tape. This checklist contains 14 items. It covers such areas as sufficient probing, failing to probe, leading and embarrassing questions, pacing, visitor attitude, listening techniques, body language, etc. Each behavior on the checklist will be rated on a 5-point scale and an overall score derived. To achieve initial certification, a child care observer must score 55 out of 70 points on the rating scale and must receive no rating of "1" on any of the items. In addition, observers must have no less than 3 H.O.M.E. items that were neither seen on the tape nor discussed by the observer and no less than 3 items which were

asked/discussed and scored based on the incorrect intent of the item.

One through three above must be met as specified in order to receive initial certification. Should one or more of the three areas not be passed, the observer must take a make-up test.

B. The Make-up test(s) taken will be determined by the test(s) failed

The procedures are:

1. Self-Administration Video Tape Failed - If the self-administration video tape was less than 90% reliable with the master scorer, but the reliability test tape and the monitoring form were passed, the observer will submit a second self-administration video tape and score sheet. If this procedure is not passed, data should be collected.
2. Certification Reliability Video Test Failed - If the child care observer does not match 41 out of 45 items with the criterion score, but the self administration video tape and monitoring form are passed, s/he will take a second reliability test. If the second reliability test is failed, the observer will repeat the entire initial certification process (a new self-administration video tape with score sheet and a

third reliability test). If this procedure is not passed, data should be collected on the H.O.M.E.

3. Monitoring Form Failed - If the monitoring form on a one of the four elements (total score of less than 55, a rating of "1" on any item, 4 or more items not discussed or seen on the tape and/or 4 or more items probed/discussed with the wrong intent) is failed, the child care observer must submit a second self-administration video tape with score sheet. If the second tape is not passed, data should not be collected.

C. **Drift/Recertification Procedures:**

Approximately mid-way through the 24 month assessment period, child care observers will take a drift/recertification test. Each site should designate one child care observer to be the site "expert" for the H.O.M.E. All other child care observers at the site will be considered "team members". The procedures for recertification are as follow:

1. Site "expert" - the person chosen to be the site expert will make a video tape of him/herself administering the child care H.O.M.E. in a child care setting. The site expert will then score the video tape based exclusively on what is seen and heard on the tape. In order to maintain certification, the site expert must have a reliability score of 90% or greater with the master

coder at the Arkansas site. The site expert must also meet all requirements for the Monitoring Form as discussed in A. 3 above.

2. Site "team member(s)" - without having seen the site expert's score sheet or discussed the tape's contents, each team member will view and score the video tape made by the site expert. In order to achieve recertification, the team member must have a reliability score of 90% or greater with the master coder at the Arkansas site.

3. Scoring for both the site expert and site team members will follow procedures outlined for initial certification. The video tape, the expert's score sheet and those of the team members will be sent to the Arkansas site by the designated date.

4. Certification Reliability Test Tape - the Arkansas site may choose to add a reliability test tape to the drift/recertification procedures. In the event this step is taken, each child care observer will take the test in the same manner as for initial certification. Each observer must score 41 out of 45 items with the criterion score sheet in order to pass. If this test is added to the drift/recertification testing regime, sites will be notified and instructions will sent with the video test tapes.

5. **Drift/Recertification Make-up Procedures** - the site expert and the team member(s) must have a reliability score of 90% or greater with the Arkansas master coder in order to pass. If the site expert fails, s/he must submit a new self-administration tape and score sheet. If a team member fails, s/he will then submit a self-administration tape and score sheet. If a team member is reliable with the master coder at Arkansas but is not reliable at the 90% level with the site expert, s/he will accompany the site expert on 5 visits, scoring the H.O.M.E. which will be administered and scored by the site expert. The expert and the member should discuss and review items (from the site tape) which were not agreed upon before beginning these visits and after each visit. Copies of these score sheets (from both the expert and the team member) should be sent to the Arkansas site with in 3 days of the visit. If 90% reliability is not reached on those scores, the team member will submit a self-administration tape. Any child care observer who fails a drift test should not collect data until make-up procedures have been passed.

D. Provisional Certification

On occasion, the Arkansas site may choose to award provisional certification to a child care observer. Provisional certification will not be awarded often or on a wholesale basis, but rather rarely and only on an individual basis. Awarding provisional certification will be based on the type and severity of errors. When provisional certification is awarded, procedures for remedial study and certification will be determined by the Arkansas site on an individual basis.

E. New Personnel

When new personnel join a site's child care team during the 24 month assessment period, initial certification procedures will follow those outlined above. Initial certification must be achieved before data can be collected.

F. Data Collection Improvement

Should the Arkansas site detect patterns of error on an individual or site basis, those patterns will be reported to the site coordinator and project directors, along with suggestions for making the necessary changes.

24-MONTH CHILD CARE VISITS ADDENDUM

Page 16: Line 9, This should say "page 62" not "page 61".

Page 164: Add "Ask one caregiver, preferably the caregiver who interacted the most with the TC, the Post Visit Interview Questions, and put this ID on the cover of this form, (Form 11W). For the End of Visit Scales, rate up to three caregivers. Choose the 3 caregivers who interacted with the TC the most over the course of the entire visit. Put these caregiver IDs in the white space on page 3 of the Post Visit Interview Booklet (Form 11W)."

Page 269: Step 2 under Behavioral Scales, change "third" to "second".

CHAPTER 22

OPERATIONS MANUAL: 24-MONTH HOME VISIT

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Acknowledgements: This manual was prepared by Martha Cox and Chris Payne with the assistance of Brian Vaughn, consultant to the Steering Committee for the 24 month Attachment Q-Set. Parts of the manual are based on earlier home manuals for the 1, 6, and 15 month home visits. These were prepared by many people. Marsha Weinraub served as chair for the 1 and 15 month home visits, and wrote the original manual upon which later manuals (and major parts of this manual) were based. Cathy Booth served as chair for the 6 month home visit. Marsha Weinraub and Susan Spieker read drafts of this manual, and their feedback was used for revisions.

CHAPTER 22

OPERATIONS MANUAL: 24-MONTH HOME VISIT

I. OVERVIEW OF THIS MANUAL

This manual provides specific information necessary for conducting the 24-month home visit. The main purpose of the 24-month home visit is to observe the mother and child going about their normal activities in the home for at least 2 hours in order to complete the Attachment Q-Set (Waters & Deane, 1985). At the 24 month home visit, the MacArthur Language Inventory and questionnaire packet also will be left with the mother and collected at the lab visit.

This manual is organized in such a way as to give general information about the visit in the first two sections, more specific information about setting up and managing the course of the visit in the third and fourth sections, instructions for activities to be completed after the visit to the home in the fifth section, instructions for unusual circumstances in the sixth section, safety guidelines for making home visits in the seventh section, and information on training for the visit, as well as specific information on completing the Q-Sort, in the eighth section.

II. GENERAL CONSIDERATIONS FOR THE TWENTY FOUR MONTH HOME VISIT

A. Your Role as a Visitor

As a home visitor, your main objective is to obtain accurate, reliable information in the most pleasant way possible. Home visitors must balance their professional role and objectives with their role of being a friendly, respectful guest in someone's home. Many unexpected things arise in the home that require flexibility on the part of the visitor. Your flexibility conveys your respect for the person and the way she does things in her home. Your flexibility and openness, however, should in no way compromise your professional agenda. The tone of the home visit is that of a friendly, relaxed yet professional visit. It will be your job as the home visitor to make the mother comfortable about having you observe in the home.

There are several ways that you can prepare yourself for this role. First, become totally familiar with the protocol. This familiarity will make you comfortable enough to be flexible and also will help keep your professional agenda in mind as you accommodate to the unique circumstances facing you. A critical part of understanding the protocol involves having a good understanding of attachment theory and the concepts behind the development of the attachment Q-Set. The training program is devised to accomplish this goal. The training program begins with readings. These are absolutely essential background readings for the observer. In general, your absolute commitment to becoming a skilled observer using this protocol is required.

Second, become familiar with twenty four-month-olds and the kinds of issues mothers are concerned with at this time. Third, you can dress the part: wear casual, yet professional clothes. Fourth, continually examine for yourself any situations that arise which prevent you from feeling totally comfortable with your role. Discuss these with your PI or site coordinator and see if there is a better way to deal with such situations in the future.

During the visit, in the event that mothers or other household members ask for more detail about the study or about what questions we are trying to answer, try to rephrase the information in the consent form or consult the information at the end of the Two-Week Telephone Interview. If people press for more information than you have, or if they ask for information which may prejudice the mother about the purpose of the study, tell the person that you are not sure what the answer is at this time, and that you'd like to check with the Director of the Project and get back to her. Never say "I don't think I'm supposed to tell you that," or "I'm not sure if I can tell you that." Families have the right to be fully informed. If you can't answer all of their questions, let them know that you will promptly get back to them with an answer.

B. About Twenty Four-month-olds

It is important for the Visitors to be comfortable with 24 month-olds and knowledgeable about their ways. Reading about twenty four-month-olds is a good idea. Site Directors often can recommend good reading material; there are several developmental textbooks that do an excellent job. Here we present a few crucial points, especially for those Visitors less familiar with children of this age.

First, as soon as you see the child, notice and comment on something positive about this child to the mother. Not saying anything is sometimes taken as a slight; saying something honestly nice is easy to do about even the most difficult of children. Be careful not to overdo it or to say anything judgmental that could be taken as negative -- even an innocent comment can stay on the mother's mind for a long time.

Do not speak to the child immediately. Wait for the child to warm up to you. When you feel this happening, you may want to greet the child in a gentle and kindly way. For the most part, you are going to be an uninvolved observer while the mother and child go about their normal routine. However, you will respond to the child's overtures and if the child has not approached you by the end of the visit, you will initiate an interaction. Note that in later sections, there are specific instructions for the way that the observer should or should not engage the child. Visitors may find it helpful to find 24-month-olds that they can spend time around in order to become more familiar with children this age.

If you feel that you may be contagious with any illness, be sure to reschedule or find a substitute. Even if you think that you are not contagious, mothers will not appreciate your coughing and sneezing around her home.

C. When the Mother Reveals Personal Problems

Occasionally, in a mother's eagerness to talk, she makes an implied or direct appeal for help with her own personal problems. The Visitor should be careful about feeling that she must handle these problems or solve them for the mother. The Visitor might say something like "I can understand your being upset (or concerned) about that. When we finish with the things we have to do, maybe we can talk about it more."

Each site has developed its own resource list to meet the needs of their families on a case-by-case basis. We will not routinely give mothers any information concerning resources. This may constitute an intervention. For example, if the list contained information about "Fun Things to Do With Your Kids," we may be subtly encouraging mothers to behave in certain ways with their children. If the mother requests this information, however, we do have a responsibility to be reasonably trained to provide information about available resources.

Researchers at each site should be relatively familiar with the services that are available to parents in their area. If a situation arises in which a mother requests information or some type of referral, the researcher may say something like, "I can see that you would like help. I am not (trained) (in a position) to help you, but perhaps you would like me to talk with Dr.---, our Director, and he/she will know of someone that could be of help to you." Immediately after the visit is completed, document the mother's concerns and requests on the 24 month home Report Form and discuss the situation with your Study Coordinator and/or Principal Investigator. Get back to the mother as promptly as possible with the appropriate information. If it seems appropriate to have your PI or SC speak with the mother, the Visitor should ask if the mother would like the Director to call.

Each site should keep a record of the kind of information distributed to a particular parent and what impact, if any, this had on the family's life, if known. (This can also be recorded on the 24 month home Report Form.)

D. When the Visitor Observes Family Difficulties

A more serious and difficult problem arises when something is revealed at the home visit that suggests that the child (or mother) is in "jeopardy". (See Principle 9 of the SRCD Ethical Standards for Research with Children.) For example, you may suspect some form of child abuse. Prior to conducting any home visits, the Visitor should become familiar with indicators of child abuse and the laws governing reporting this to the authorities in your state. You should immediately report to your PI any instance of abuse or suspicions of abuse. A list of indicators and definitions of child abuse, prepared by the Wisconsin site, is included in Appendix A of Chapter 6.

E. The Key to a Successful Visit

As much as possible, the 24-Month Home Visit should be pleasant and satisfying for the families. In this regard, it is helpful for you to see this as a friendly visit. The Visitor must be as relaxed as possible and try to help the mother feel relaxed as well. On first entering the home, spend a few minutes just chatting. "How have you been?" may be reasonable to ask, or you may discuss any other topic of common interest (the weather). Making positive comments about the house, children, pets are all things that make people feel more relaxed and positive toward you. In other words, be a polite, friendly visitor to the home, showing you are interested in the family as people as well as in the information that they can provide. At the same time, in this visit you must convey to the mother that we need to have her and the child go about their normal routine to allow us to observe a "natural slice" of the child's life. It will be easier for the mother to do this, however, if you have made her feel more relaxed about your presence when you first enter the home. It is important to the success of these visits that you are able to make the mother feel relaxed and comfortable about these observations. Sometimes recognizing that it is awkward helps such as saying something like, "I know its hard to have someone in your home observing, but this is the only way we can see what (child) is like at home so just try to relax and ignore the fact that I'm here and go about your normal activities."

F. Sharing Personal Information

In your conversation with the mother, you must avoid sharing personal information. By sharing such information, you may inadvertently establish certain response biases in the mother as she assesses what your values may be. The reliability and validity of the data depend upon the Visitor being able to establish an interpersonally neutral atmosphere. Making evaluative statements after the mother answers a particular question, making evaluative comments on behaviors observed in either mother or toddler or sharing personal information with her are major ways that a Visitor can introduce bias into the data collected. The Visitor is better advised to ask the mother what she thinks than to express the Visitor's own opinion.

G. Expressing Appreciation

Be sure to emphasize at some point during the visit the importance of the mother's contribution to the research, how worthwhile and important the research is, and how much the mother's time is appreciated. This is often a good thing to do as you are leaving, if it hasn't come up before. Say something like, "We really appreciate your time. This research is important to understanding how early experiences affect how children develop, so we appreciate that you are willing to help us with this."

III. THE VISITOR

One visitor will collect data for the visit, except for the visits designed to establish within site reliability. Two visitors will go on those visits. Six of these reliability visits should be done between each pair of observers. These site visits should be spread over the data collection period. The visitor for any given family should be different from the research assistant who observed the same child in child care at 6, 15, or 24 months or the same child in the lab at 15 or 24 months. Preferably, the visitor will be someone who is familiar to the family and who visited the family in the home at 1, 6, or 15 months. If, for some reason, the 24-month home visit cannot be completed in one visit, the same visitor should conduct the follow-up visit.

IV. CONDUCTING THE TWENTY FOUR MONTH HOME VISIT

A. Window for Data Collection

The 24-month home visit will be scheduled and occur between 24 months and 0 days and the day prior to 26 months 0 days. For example if the child's birthday is August 15, the scheduling window will be August 15 to October 14. Every effort should be made to complete data collection within this window.

If, however, the visit must be canceled for some reason or cannot be completed and must be rescheduled, you may reschedule at a later date, up to but not including the child's 29-month birthday. Data collected on or after the child's 26-month birthday should be flagged as collected during the "exception period" by completing and sending an "Exception Period Data Collection Form" along with the data to the DCC.

Although it is preferable for the home visit to precede the child care and lab visits, this may not always be possible. If the lab visit comes first, be sure to have the lab team give the mother the MacArthur Language Inventory and questionnaire packet to be collected at the home visit. If you are collecting the Language Inventory and questionnaires at the home visit, remind the mother to complete it when you make your call confirming the appointment. (See detailed guidelines for administering questionnaires in Chapter 23.6)

B. Equipment Needed for Visit

You may want to carry all the forms and materials in a canvas tote, arranged in order. You will want to bring additional copies of the forms, in case anything happens to this set. Be sure to take the mother's full name and address and phone number, in case you need to contact her on your way. This information should be recorded on the face sheet of the visit form before leaving for the visit.

You will need the following:

1. Map
2. Directions
3. Writing Board
4. Several #2 Pencils

5. Paper for notes
6. The Multi-purpose cover sheet
7. The Observation Report Form
8. The Post Home Visit Interviews with Mother; Form 15Q and Form 24P
9. The Attachment Behavior Q-Set
10. The Attachment Q-Set Item List and Note Form
11. The Attachment Q-Set Recording Form
12. Items for Staged Situations (Snacks, Books)
13. An envelope to put completed data in
14. Subject payment and a receipt book for subject payments or forms to sign for obtaining payment (method of payment to be determined by sites)
15. Postcards to notify lab as address changes occur
16. Directions for the mother to get to the laboratory and maps, if necessary, or information about how to arrange transportation to the lab
17. Information for the mother about parking at the lab
18. A card for the mother with the date of her lab visit and the telephone number of the lab
19. The questionnaire packet is prepared by the 23 month phone caller
20. A stamped envelope in case the mother needs to mail in the MacArthur Language Inventory and questionnaires (when the lab visit went first and mother hasn't completed the MacArthur and/or questionnaires)

21. Audiotape recorder for reliability taping (voice activated) *See addendum

22. Audiotape and batteries *See addendum

23. Operations Manual

A checklist for protocol materials has been included on the face sheet of the home visit form.

C. Pre-Visit Preparation

A 23-month phone call (between 22 and 24 months) will have been conducted to gather child care data and schedule the 24-month home and lab visits. In scheduling the home visit, we will ask the mother for a time that the child is rested. We also will ask the mother for a time when there have been no unusual separations (overnight) between mother and child in the week prior to the visit. We also will tell the mother that we need a time when just the mother and child and younger siblings (if any) are home.

We are only observing for 2 - 3 hours and what we saw in the many pilot visits that we did was that when others were present, the child's interactions were so distributed that it was difficult to do the sort for CHILD AND MOTHER. A 2-year-old can play happily with an older sib for 2 hours in a bedroom and never need to check in with Mom because there is security derived from the presence of the older sib. If you are observing and Dad walks in after being gone all day, his presence is new and novel and very likely the child will spend time around him. Again, because you need to sort with regard to MOM AND CHILD, you are out of luck. So there is the practical issue of whether you will actually be able to get the information required if others are present.

On the other side are households in which the Mother simply cannot require that others be out of the house. Even with incentives (passes to movies etc.), it may not be possible for some families to have only mother and child (and younger child) present. Here are the decision rules for scheduling:

1. We should try very hard to schedule a NATURALLY OCCURRING TIME when mother and child (and younger child) are the only ones home. The RA making the call should try to ascertain if that ever happens, when it happens, and schedule then. She should explain to the mother that because we are focusing IN THIS PARTICULAR PART on mother and child, we need to see just mother and child as much as possible. If your site is willing, to help such a "naturally occurring event occur", it is fine to offer incentives for an adult besides the mother (father, grandmother, other adult) to take other children out to movies or to a special event.

2. If it is impossible to have everyone else out of the house, the RA should determine if there is a time when the presence or involvement of others would be minimized (in terms of numbers of others present being at a minimum, in terms of other important caregivers not being present--i.e., Dad or another adult relative who provides major care --, and in terms of times

when others could be relatively uninvolved with the child--i.e., Dad is asleep or Grandmother is doing the laundry). In this case the RA should recognize that she might have to stay a bit longer to get the information (or come back a second day) and the 3 set-up procedures may be necessary.

3. If it is impossible to have anything but a situation where many people are present in a small household, I think that the RA should do the observation, the RA probably would need to stay longer or come back a second day, and RA probably would need to do the 3 set-up procedures.

The RA would record their confidence level for each particular sort, as well as the extent to which the situation was optimal for doing the observation. We can use these ratings (particularly the confidence rating) to look at whether findings are different when we include those sorts for which RAs had little confidence and situations were not optimal.

So, we can see the families if the only time possible is with other family members present. However, we want the RAs to try to find a time when others are not present. Please try your hardest to schedule when just mother and child and a younger child are present.

Another reason for trying to schedule all families when just mother and child are present is that we may find ourselves more likely to schedule children of employed moms when others are present. If we start observing the children of employed moms with a lot of other family members present, while we observe the children of unemployed moms with just the mother present, we have big problems.

So to summarize, what we are trying to do is observe just mother and child (and younger sib, if any). If we cannot do that, we have ways to record who was present, how confident the RA was about the sort, and how optimal the situation was. We can then analyze the data with and without the cases in which others were present, the confidence is low, and the situation was not optimal to see if we get different results. We should monitor at each site whether we have a bias in the way that employed versus unemployed mother families are being observed. So please keep track of that at your site as you schedule families.

One to two days before the scheduled visit the mother should be re-contacted to verify the time and date of the visit and that this is still a rested time for child (i.e., naps have not changed) and that there have been no major separations in the last week. During this confirmation call, remind the mother that you will bring a snack and check with her about child's food preferences. If the mother does not have a phone, she should be re-contacted in whatever manner has been previously arranged so that she receives a reminder within two days of the visit. If visits are scheduled more than two weeks in advance, mothers may have difficulty remembering their appointments with us. Sites may want to send the mothers reminder postcards 7 days prior to her scheduled visit.

Before going to the home there are at least two things to do to prepare for the visit. First, the Visitor should check a map to make sure that the directions received from the mother are correct. Checking the map will also help the Visitor plan the time she needs to find the mother's home and to anticipate delays. Second, the Visitor should check that all necessary supplies, materials and equipment are packed and ready to go.

D. Rescheduling

Despite attempting to schedule the visit when the child is awake, it is possible that the child will be asleep when you arrive. If that is the case and the mother expects the child to sleep for a long time, you will need to reschedule the visit. If the mother anticipates that the child will be up shortly, ask her if she would like you to come back in a short time or if you should stay. If the child falls asleep soon after you arrive, you will need to reschedule the visit (preferably within a weeks time) and you will base your Q-Sort on both visits. If the child falls asleep or there is a problematic interruption, if you have been there for nearly two hours and you feel you have sufficient information such that your observations were made over a long enough period of time to feel confident about them (i.e. they do not distort the reality of the parent-child interactive behavior and non-interactive behavior), you will not need to reschedule.

Although the conditions needed for the visit should have been discussed with the mother when the appointment was made, occasionally you will arrive and find that conditions exist which make the visit impossible to do or unrepresentative of the child's home environment; for example, unexpected company has dropped in or many family members are there and are staying. In general, if you feel the situation does not deviate too much (for example, one family member is there but out of sight) and if the mother is still willing to do the visit, go ahead and do the observation. Short interruptions (phone calls, deliveries) need not be a cause to reschedule unless the child appears disturbed by them, or the mother states that the visit represents very atypical circumstances for the child. If other children are present in the house and they are not usually there, it will be difficult for the observer to get a sense of what is typical. The visit should not be completed under these circumstances, but rescheduled. However, if the other children are siblings and are not involved (outside playing etc), use your judgement about whether the observation should proceed. The general rule is that if the situation is no longer representative of the child's normal home environment or you won't be able to observe enough of the items because the child's interaction is distributed among too many people, reschedule the visit.

If the child is truly ill, you must always reschedule.

At the end of the 2-3 hour visit, if you feel that you do not have sufficient information to complete the sort, you must come back for a second visit. Base the sort on both visits. This will happen occasionally. In this case try to come back within a week. Make sure you have good notes and you also can do a preliminary sort and take notes about that. These will aid your memory for a final sort. Even if the second visit is delayed, good notes will allow you to use information from both visits.

E. Arrival

1. Establishing initial rapport

Upon arrival at the mother's home, offer a friendly greeting, ask how everything is going, etc. For example, "Hello Mrs. SURNAME, I'm VISITOR's NAME from the Early Child Care Study at YOUR SITE. It's nice to see you again (if previously seen). I appreciate your letting us come out and visit with you today. How has everything been going for you and CHILD?..."

You may want to say something nice to the mother about the child, but don't talk directly to the child just yet. Let the child approach you.

2. Giving an overview of the visit

After introductions, convey something like the following script to give mother an overview of the visit:

"As (give the 23 mo. phone caller's name) told you, in this visit we will be trying to get some information about the child's experiences and activities. We would like to observe the child as you go about your normal activities around the house. Because we would like to see as natural a slice of the child's home life as possible, we would like you to do whatever you would normally do at this time. I may ask you about things from time to time, but in general please just ignore me and go about your normal activities. We would like for you and the child to be here during the full 2 hours. We prefer that others not be here except when they are just coming and going quickly because it is hard to see what (CHILD) is like with you if others are here for him/her to interact with. During the first half of the visit I will generally just observe you and CHILD although I may ask some questions. During the second half, I will probably ask you about some things I may not have seen during my visit. We have several experiences that we like all familes to have so I've brought a snack and a book for later." If there are interruptions, like deliveries or phone calls, these are considered part of the normal day of the child, and the mother should not feel that she cannot proceed as she normally would.

If it has been impossible not to have others there (father or other adults who live there or older siblings), make sure that the mother knows that we need her to remain in the household for the observation period. Also make sure that she knows that it is fine for siblings and the father to come and go as they normally would.

3. As the observation proceeds

As you begin the observation, in the unlikely event that the child and mother are in different rooms and are having no contact and this goes on for 15 - 20 minutes, you can go in the room with the mother and talk to her. That will usually serve to draw the child to that room, especially if he was staying in the room with you to "observe" you, the novel stranger. If the child does not come into the room where the two adults are (and there is no one else home), that is interesting information.

It is important that the observer and the child have some contact at some point. However, it should be at the child's initiation. At the end of the 2 hours, if the child has not initiated with you, then offer the child a toy or a cookie. As it is appropriate to elicit the "new adult" or visitor items, you can interact with the child. You will get a sense of this in training.

At the end of the 2 hours, you will ask the mother if this is what would have happened in general if we had not been there. However, as things arise during the visit, you can also ask the mother that question about specific things.

As the observation proceeds, you will ask the mother about behaviors you haven't seen and about how typical the behaviors are that you have seen. You will use a more open approach to soliciting information rather than a structured interview approach. This approach will be a major focus in your training to do this visit. In soliciting this information, it will be important that you are sensitive to the intent of the Q-set items and skilled at putting mothers at ease. The more "clinical" approach to seeking information from the mothers will yield better information. If you simply repeat the item content to the mothers, you are more likely to get a blank stare or glib, quick, socially desirable responses. It is best to initiate the probes with explicitly observed child behaviors. So, for example, if the child appears wary early in the visit and then warms up, you would ask the mother how typical that is, does it happen more with males or females, then what happens when the child is frightened, does he or she want to be held in those circumstances. When you can't use observed circumstances (for example when you need to sort the child's response to mother's reprimands and the mother never reprimands the child), describe for the mother a "representative" vignette of mother-child interaction and ask how the child might respond in that circumstance (for example, when the child is going to touch something breakable or dangerous and you reprimand her, what does she do?).

Exactly how and when questions are put to the mother will depend somewhat on the observer and what is "observed" in the course of the 2-hour home visit. Although some interaction with the mother is necessary and inevitable at the outset of the observation, you will want to make it clear that your visit is intended to gather information about the child from direct observation of the child's behavior. Nevertheless, the mother should be informed that many of the items which must be considered by the observer occur only rarely and will be more often be observed by the mother. Consequently, you will spend some time talking with the mother about relevant content that you were not able to observe (for example, item 26 refers to the child's typical response when left at home with a baby-sitter, father, or grand-parent, which should not be observed by you). Generally, it is easiest to cover this content in a conversation about the child, rather than as a question-answer format at the end of the observation period. However, if you find it easier to use a standard format in which you simply refer to the items as questions, you may do so (e.g., "How does X behave when you leave him/her at home with a baby-sitter or father? Does she/he cry? etc.). By convention, not as much credit is given to items obtained solely by maternal report (they are usually not sorted in the most characteristic or least characteristic piles). However, the information will be useful in distinguishing between items placed in the middle piles (somewhat characteristic versus somewhat uncharacteristic, for example). More information is given about this in later sections.

The following interaction tasks will be used at some point in the two hour observations, if needed. Because the observation period is so brief, many behaviors aren't observed. The mother can be asked about these, but these interaction tasks may help elicit these behaviors so that they can be directly observed. Each of the three of these tasks would entail interaction between mother and child. They might be massed (done as a group) or distributed across the observation period, as meets the individual needs and desires of the families and observers.

The interaction tasks should not be initiated until the observers have been in the home for at least an hour. (The exception is that we may offer snack early if the mother indicates that she is preparing the child something to eat.) This will give time to see much of what happens when the child meets new people and how she or he uses the mother as a base of exploration and support. The observer may find that these interactions occur naturally and don't need to be staged. Conversely, the observer may find that little interaction has occurred between mother and child and that the tasks are needed.

The three interaction tasks are conceived as giving more and more control to the mother in the direction of the interaction and for this reason you may desire to order them according to the mother's increasing role. Alternatively, you could leave the order up to the mothers themselves.

One interactive vignette entails the mother and child playing their favorite physical interaction game. The best game to use is hide and seek. Some children may be unwilling to let the mother go out of sight and that is useful information. Others may be willing to hide themselves, but not have the mother hide and others may be comfortable letting the mother hide. Playing chase is another option, but almost all children will enjoy that game and you may not obtain as differentiating information. The RA could introduce this vignette with the following script: "Many children this age enjoy playing hide and seek. Has CHILD ever done this before? Could you try hiding and having him/her find you?"

If in the course of observation the child separates from mother (goes in another room), you may not need hide and seek, but it is still good to ask the mother if they have ever played hide and seek and if the child likes to play it.

Another interactive vignette is the reading of a book to the child by the mother. A short book would be ideal for attracting the interest of the children. The RA could introduce this vignette with the following script: "We have brought a book for you to share with your child. If you would like to sit down together, you can share this with CHILD. It has lots of interesting things that the children enjoy. You do not have to read it, but can talk about it together." In previous research with children at this age, "read a book" has been an excellent task for eliciting individual differences in maternal interaction styles and these in turn are associated with variable child behavior. If you know the mother can not read, we will have a book without words that can be used.

The other interactive vignette is "snack." The observer should bring drinks (apple juice) and cookies or crackers (a box of animal crackers works well) or other foodstuffs the child is known to prefer. Obviously, the mother must be contacted for food preferences in advance and an understanding that a snack will be brought should be reached prior to the visit (in confirmation call for 24 month home visit). Tell the mother that we wish to bring snacks ourselves so that it is standard from family to family. If the mother says, no, I will be giving him/her a snack and prefer you not, encourage the mother to let us bring the snack. If she still says no don't bring anything. If you do bring a snack, it is preferable that the drink container be too large for a single serving. That is, the child will not be expected to drink directly from the container or, excepting a very motorically precocious 24-month-old, be able to pour on her or his own. Two 12 oz. bottles of apple juice (like what is being used at the 15 month lab visit) should be sufficient for this. Observers could provide napkins, cups (to imply that the drink needs pouring), and the consumables. This will give ample opportunity to observe compliance with directions, probably some prohibitions, positive affect, etc. Again, snack episodes have proven quite useful in previous research in terms of revealing substantial differences among mothers and children's behaviors. The script to introduce this vignette is as follows: "We have brought a snack for you today. Is this a good time for CHILD to have a snack? There is enough for both of you. We've brought cups so that CHILD can pour the juice."

The total amount of time taken by these vignettes will be determined in part by the willingness of the subjects to "perform" in front of you. It is the observer's task to make the mother feel at ease about this. Each of the vignettes is complex enough to take 5 - 8 minutes. A total of 15 - 20 minutes is more than enough to extract the item-relevant information you are seeking. Certainly, these vignettes should take no more than

23-25 minutes from the total observation period. 25 minutes is really too much. On the other hand, you may not see all you need in less than 15 minutes. There is a great deal of redundancy built into the three vignettes.

That is, in each there will be opportunities to assess cooperation, compliance, affect, etc. Responses to physical contact with the mother will be possible in the game and story episodes. Responses to directives will be most likely observed during snack etc. It appears that the "play a game" vignette will be the most variable in terms of the return on investment of time.

As the observation period proceeds, you will need to take good notes concerning the relevant behaviors that you observe and the information you get from the mother (more information on note-taking is provided later). Keep note of the behaviors that you don't observe so that you can ask the mother about them. At the end of the observation period, you should have observed or asked about all 90 of the Q-Set items.

In some rare cases, you may find that at the end of the 2-3 hour visit, you do not feel confident that you have enough information to do the Q-Sort or that the Q-Sort is not valid (this may occur when the mother indicates the child's behavior was very atypical and should be rare). You may not have enough information because there were many interruptions, the child went to sleep, there were others present, or just because it was an unusual and difficult visit for a number of reasons. You may find that there are a large number of items that you have not observed (say more than 30 or 40) or that you do not have a sense of the items that you will place in the top 2 and bottom 2 piles. In that case, at the end of the visit, tell the mother that you need more observation time to complete the description. Ask if you can stay longer or if it would be possible to come back at another time. Tell her that you had not expected this, but it does happen some times, that you are sorry, that you will pay her for the second visit, and that you appreciate her cooperation. If the mother refuses to have you come back, complete the sort if you can, but give it the lowest confidence rating.

F. Exiting

1. The Observation Report Form.

The visitor will complete the Observation report form at the end of the visit. The Visitor should always ask the mother if this 2-3 hour period was typical for the child and record the mother's answer. The visitor also will record who was present for the observation and any unusual events that occurred. At this time the visitor will give the mother page 3 of the 24-Month Post Home Visit Interview-Part 2 (Form 24P) to complete. Questions 8 & 9 on the Post Home Visit Interview with Mother-Part 1 (Form 15Q) are not asked by the visitor. These two questions have been added to the end of Form 24P for the mother to compete.

2. Debriefing

It is important at the end of the visit to "debrief" the mother. Ask the mother if she has any comments or questions about the visit she would like to share with us. The Visitor needs to be sensitive to any negative affect in the mother and needs to give the mother a chance to share her feelings. If the mother asks questions about the research hypotheses, try paraphrasing the information for the families in the consent form and two-week phone call. This is necessary to give the mother a sense that she is an important part of the research process, to give her the chance to tell us if the visit captured out-of-ordinary circumstances, and to express any adverse feelings she may have had about the visit.

3. Leaving the MacArthur Language Inventory, and Questionnaire Packet

The standard protocol calls for Home visitors to leave the MacArthur Language Inventory and the questionnaire packet at the home visit for the mothers to complete and bring to the lab visit. Should mothers not be able to read, the questionnaires are to be administered at the lab visit.

However, there are a number of ways in which this protocol may need to be revised: the home visit takes place AFTER the lab visit, the mother forgets to complete the questionnaires before the lab visit, the mother needs assistance with the questionnaires and this was not done at the lab visit for whatever reasons. In these circumstances (and any others we have not envisioned), please use the guidelines below.

Guidelines:

1. Always hand out questionnaire packet at the first visit, (Home or lab). In most cases, this will be the home visit. Enclose a stamped, lab addressed mailing envelope with the packet.

2. Pick up the completed questionnaire packet at the next visit.

3. The lab team is always responsible for follow-up, to be sure that they have the completed data and that they send it to the DCC.

4. At the second visit, usually the lab, but possibly the home visit, the questionnaire packets are collected. If the mother does not have her packet, she may be given a second one. However, all mothers will be paid for their visit, whether or not they return their questionnaires.

5. If there is some concern that the mother may not be able to complete the questionnaire on her own time and return them via mail, sites may choose to have the mother complete the questionnaires at the lab visit. This assumes that both the mother and lab team have the additional time required.

Below is a detailed list of instructions for implementing these guidelines.

1. When the lab visit precedes the home visit: Guidelines for the lab team

a. Give the mother a manila envelop with the macArthur and common protocol questionnaires. Attach postage to the envelop and address it to the lab, so that it can be mailed back, if the mother wishes or if the packet is not picked up at the home visit, for whatever reason.

(1) Tell the mother that we would like her to complete these materials in the next few days, and that we will pick up the packet when our home team visits her in her home.

(2) Alert the home team to pick up this packet at the home visit. When the packet is returned, the lab team can consider this subject's materials completed.

(3) If the packet is not retrieved at the home visit, it is the lab team's responsibility to call the mother a reasonable number of times (at least two), within a reasonable period (3 to 5 days after the visit) to retrieve the completed material.

b. If past practice has shown difficulties with the mother returning materials by mail, and if the lab team is able to spend the additional time with the mother and child to compete the questionnaires (40 minutes total: MacArthur: 20 minutes, Questionnaire packet, 20 minutes), the mother may be invited to complete them during the lab visit, after the completion of the height and weight measurements.

Some mothers may not be able to spend the additional time; other mothers may welcome the free child care and comfortable space that we offer her to get her questionnaires done "on the spot". Having the mother complete the questionnaires at the lab visit is desirable (when possible), because then we are assured that the questionnaires are received. Mothers may not be able to complete them by the time we visit the home. Administering these materials at the lab visit, we can avoid additional postage and time-consuming follow-up calls.

(1) In these circumstances, if the lab team determines that they do not have the additional time, or if the mother cannot stay to complete both the MacArthur and the questionnaire packet, then perhaps there is time to complete just the MacArthur Language Inventory (20 minutes). If so, do so, and give the mother the questionnaire packet to be picked up at the home visit.

c. If the mother needs help in completing the questionnaires, (i.e., she cannot read), the lab team should prepare to administer the MacArthur and questionnaires at the lab visit. Additional time will need to be scheduled, and the mother should expect to stay at the lab visit for at least three hours to complete the Common Protocol.

(1) If there is any problem administering the questionnaires, they can be administered over the phone, on a separate lab visit, or if necessary, after the 24 month home visit.

e. In any case, pay the mother for the lab visit.

2. When the lab visit precedes the home visit: Guidelines for the home team:

a. If the lab visit takes place before the home visit, the home team should be on alert. They will need to find out from the scheduler or from the lab team whether they are to retrieve or administer questionnaires at the home visit. If so:

(1) At the confirmation call, the caller should ask the mother to please have the questionnaires completed and ready for pickup at the home visit. If the mother has not completed them yet, the caller should ask the mother to see if she could try to find time to do so before the home visit.

(2) At the home visit, the home visitor should retrieve the completed questionnaires. If they are not completed, the visitor should ask the mother to complete them in the next few days and return them via mail in the lab-addressed stamped envelop provided. The home visitor should offer the mother another lab-addressed, stamped set of materials, in case the mother has misplaced them.

(3) If the mother is a nonreading mother, and for some reason the questionnaires were not administered in the lab, then the home visitor should prepare to administer these items in the home after the observation. Mothers should be told on the confirmation call that we will need to schedule approximately 3 hours for the home visit. If this cannot be done, then the lab team needs to be informed that they need to call the mothers to

schedule a time to administer the questionnaires over the phone or at the mother's home.

(4) After the home visit, the home visitor should convey the questionnaire packet to the lab team or inform the lab team of their status.

(5) It is the lab team's responsibility to contact the mother for the questionnaires. They should call about at least twice, between 2 and 5 days after the home visit is completed.

3. When the home visit precedes the lab visit, but the mother does not bring the completed questionnaires with her to the lab: Instruction for the lab team.

a. If the mother has completed the questionnaires, but has simply forgotten to bring them, the interviewer should ask the mother to please return them via mail. The envelop she has does not have postage, so the interviewers should give the mother a stamped lab-addressed envelop with which to return the materials. However, the interviewers may also explain that, just in case she has any trouble locating the completed questionnaires, the interviewers has paced a new set of materials in the envelop. The mothers should remove these and put in her completed questionnaires and drop the packet in the mail.

(1) By enclosing an additional set of materials, we can speed their receipt, in case the mother has misplaced her original set.

(2) The lab team should call the mothers at least twice over the next 2 to 5 days to encourage the mothers to put the materials in the mail.

b. If the mother has not completed the questionnaires, the interviewer should give the mother a new set with a stamped lab-addressed envelop with which to return the materials. Follow the same guidelines as in XX above.

4. When there is a home visit, but no lab visit: Instruction for the lab team.

It is the lab team's responsibility to retrieve the MacArthur interview and questionnaire packet. In calling to contact the mother to schedule or reschedule the lab visit, the team member should encourage the mother to return the questionnaire packet within the next week, even if she cannot make the lab visit. This information is very important to us, and we value her input. Sites can offer to send the mother a $15 check on receipt of the completed materials.

5. When there is a lab visit, but no home visit: Instruction for the lab team

It is the lab team's responsibility to retrieve the MacArthur interview and questionnaire packet. The team member should call the mother and encourage her to return the questionnaires packet with in the next week, even if she cannot make the home visit. The packet we gave her is already stamped and self addressed, and all the mother needs do is fill out the questionnaires and drop it in the mail. This information is very important to us, and we value her input. Sites can offer to send the mother a $15 check on receipt of the completed materials.

6. When all else fails, lab team members can feel free to complete the questionnaires over the phone with the mother, if this is acceptable to the mother, of course. Sites can pay the mother for her time on the telephone, just as if we were getting this information in the mail from her. When questionnaires are completed over the telephone, this needs to be indicated on the questionnaire log.

4. Paying the Mother

Thank the mother for all her time and help. Explain how important this study is, and how we value her time and help. Pay her $30.00, or make arrangements to pay her.

5. Preparing for the Next Contacts

If the mother has not yet had her 24-month lab visit, the most important order of business here is to confirm the time and date of that visit and go over with the mother information about how to get to the lab and, if appropriate, where to park. Written directions as to how to get to the lab or how to arrange for transportation may be necessary at some sites. Remind the mother that someone will call to confirm the time and date of the lab visit on the day or two before the visit. If the mother tells you that the scheduled lab time is no longer convenient, either reschedule her on the spot or tell her that someone from the lab will call to reschedule.

Mothers may want to know what will happen at the lab. You may tell her that we will be observing her child playing first. We will also have some special activities for CHILD, and we will be watching to see what the child does. We will want to ask her some things about the child and her family and have her complete some brief questionnaires (sites add site-specific descriptions). If the mother has already had her lab visit, say something like:

"The next time we visit you in the home will be when CHILD is 36 months old. At that time, we'll be talking with you again. We will also want to watch CHILD doing some things that may be fun for her to do with you. There will also be a lab visit at 36 months of age. We will contact you a few weeks before CHILD is 36-months old to talk with you about the details of these visits. If at 36-months CHILD is in (still in) some form of regular child care, we would also like to visit her while she is there. When we call you to arrange our visit at 36-months, we'll also want to contact the caregiver. We will (will again) pay the caregivers for their time and help."

"Someone will call when CHILD is 27-months to talk with you about whether CHILD has been sick or whether you have changed your child care arrangements".

Leave the mother a business card or some small information card with your name on it that she can file or "put on the refrigerator." If the lab visit is scheduled, be sure to have the

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date and time of the lab visit on the card. If the lab visit is to be rescheduled, have the original date on the card, crossed out. Say, "We'll be in touch with you, but if anything changes for you or if you want to contact us, please call. Our number, and my name, is on this card."

G. Departure

Leave the mother with a good feeling about your visit. As you leave, give the mother positive feedback along the lines of "You've really been helpful to us," "I've enjoyed meeting you, I'll look forward to visiting you again," "You really have a beautiful child."

V. POST-VISIT ACTIVITIES

A. Doing the Q-Sort

After the visit is completed, the visitor should proceed to a quiet place directly and complete the Q-Sort. The Q-Sort MUST be done immediately after the visit. It must never be put off till later in the day or the next day. Your notes will be important here.

After the observation period is over, the observer should carefully read over their entire set of notes. Then take the Q-set deck and review the content. With notes taken during the observation serving as a guide, the observer initially divides the Q-set into 3 piles of items: 1) Those items that are NOT LIKE, or are UNCHARACTERISTIC of the observed child; 2) Those items that are LIKE or are CHARACTERISTIC of the observed child, and 3) Those items that are BOTH LIKE AND UNLIKE the child. These three piles are then further divided. Regarding the third stack, sometimes items seem to characterize the child at one point in the visit, but not at others or these items were never observed. All information received solely through the mother's report should initially go into this third stack. Note here that you may have observed a behavior and then asked mother if behavior was typical. These items do not need to go in middle pile because you observed them. Place them there only if that is where they truly belong, not because you asked mother. For some items you will have observed the behavior and received clarifying information from the mother as well. You must use your judgement concerning the saliency of the item based both on observation and maternal report. For a fair number of the items, you will have to rely completely on maternal report. These reports should be treated as data, but not as meaningful as directly observed behavior. Occasionally when the visit has been especially unproductive in terms of observed behavior you will need to sort some of these maternal report items into more extreme categories. Detailed information on completing the sort is provided in Section 8 on Training.

B. Documentation of the Visit

To document the visit, the Visitor will need to complete some forms after leaving the home. These will be done after the Q-Sort is completed.

1. Observation Report Form

On this form the visitor will record any comments about the home visit. This will include who was present during the visit, any interruptions or unusual circumstances that occurred. This form is filed in the subjects' personal files at the site.

2. Log Book

We also recommend that each site keep an informal log book on each visit. Here you could include information about who the Visitors met during the visit, general comments about the proceedings, and note some non-protocol information about the visit such as things the Visitor may have discussed with the mother, the name of the family dog, etc. This information may be useful in maintaining rapport during future contacts. Be careful not to include information that may bias future Visitors; only information that may help them respond as sensitive, friendly visitors to the family.

C. Posting the Data

See Chapter 3, "Data Management and Paper Forms Handling" for information on posting the data forms to the Data Coordinating Center.

D. Maintaining Rapport

BEST COPY AVAILABLE

Each site will send some type of thank-you note to the families after both the home and lab visits are completed. Each site can decide the form of the note with which they feel most comfortable. All sites will send the children yearly birthday cards. Each site can also decide whether they want to send holiday cards.

VI. ENCOUNTERING UNUSUAL CIRCUMSTANCES

Listed below are some situations that may be encountered on the 24-month visit and our suggested solutions. We realize that each site is different and we invite your comments and suggestions.

1. The Visitor arrives and the mother is not home. Do we call and reschedule her?

Before leaving the area, the Visitor should attempt to call the mother from a nearby phone booth to make sure that she really is not home (e.g., her doorbell may not be working). If the mother is not home, the Visitor or the scheduler should attempt to contact the mother as soon as possible. Every attempt should be made to reschedule the visit within the allotted time frame.

2. The mother refuses to participate once the visitor arrives at the home. Do we pay her?

If at all possible, the Visitor should try to determine exactly why the mother refuses to participate before she leaves the home. By keeping accurate records of refusals and drop-outs, we may have some insight into the biases that may creep into our sample. If the refusal is related to specific circumstances of the day or week, then arrangements to re-contact her and reschedule the visit should be made. As for paying her, we do not have to, considering that the money is for participating in the study. We should thank the mother for her earlier participation and leave. The P.I. or Study Coordinator will want to decide how to follow up on this situation.

3. The Visitor arrives at the home and the mother says that she or the child is not feeling well and she wants to reschedule.

The Visitor should try to determine why the mother did not phone the lab to cancel her appointment. Is this a sudden illness that may have prevented the mother from contacting us? The Visitor should offer to reschedule if the mother or child was truly ill and the mother was too busy or too distracted to call us. If possible, she should be rescheduled on the spot. However, it may be that neither the mother nor her child is ill; the mother just does not want to be in the study anymore. The Visitor should verbally check this out with the mother. If the mother does not want to be rescheduled, the Visitor should thank the mother and politely leave. Tell your SC or PI of the circumstances when you return to the lab/office. The mother will be called and rescheduled if possible.

4. The mother is very hostile, uncooperative, high, etc. What do we do? Will we see her again?

If the mother is merely uncooperative or somewhat hostile, the visitors may want to switch gears and allow the mother to do more open-ended talking for a while. If this does not help, the visitor should reassure the mother that her participation is strictly voluntary and that if she finds the questions or procedures in any way a problem, she can withdraw at any time with no penalty.

If the mother is overtly high or psychotic, the Visitor should leave the house as soon as possible, as tactfully as possible. Data from the 24-Month Home Visit will be missing in this case, but the mother will be contacted again at the next scheduled data collection.

5. What if we/she has to leave before finishing the observation?

A return visit will need to be scheduled if you are not confident that you have observed for a sufficient period of time to be able to complete the sort and feel it represents the child-mother interaction.

6. What if the visitor(s) see indicators of child abuse or potential abuse?

This information should be reported to the PI immediately. If required by state laws, this information will need to be reported to the appropriate authorities. If the family still wants to be in the study, they should still be included. This information must also be reported to the Data Coordinating Center.

7. If a child dies unexpectedly before the twenty four month visit, is it appropriate to send a card?

It is appropriate to send a note of sympathy. Each site can decide how they want to handle this situation. The Temple site would recommend sending a card which includes the phrase, "If there is any way that we can be of help to you, please let us know."

8. If the mother and her child are not living together in the same household at the time of the twenty four-month visit, what do we do?

If the legal guardian or the person who has been taking care of the child has agreed to participate at the 23-month phone call, schedule the visit and do the observation with that person if he/she has cared for the child for at least 2 months or has had a consistent relationship with the child for at least 6 months (seen the child on a weekly basis) using the appropriate alternate caregiver forms. Do not drop the original family at this point--the mother and child may be reunited later.

VII. SAFETY GUIDELINES

Occasionally, home visitors will have to go to an area with which they are unfamiliar. In some cases, they may have to make the decision not to collect the home data at 24 months because the family's home is unsafe to visit for some reason. It is, therefore, essential that visitors be able to evaluate the safety of an area and learn how to increase their safety when traveling in unknown areas. We have compiled two lists to help visitors with these tasks. These indicators are only imprecise guide-lines. The presence of these indicators does not necessarily mean that the area is unsafe, nor does the absence of these indicators necessarily mean that the area is safe. These are meant only as indicators to consider. Sometimes visitors will have to go on their 'gut reaction'. Remember -- the safety of home visitors is paramount! Never enter or stay in a situation in which you feel threatened.

A. Things to consider in evaluating the safety of an area.

There are three significant characteristics of dangerous areas: isolation, evidence of drug use or criminal activity, and a general air of abandonment. Remember that the presence of these characteristics do not always indicate danger, but they are signs that should be attended to. Some indicators of dangerous areas include:

Isolation

Poorly lit areas

People walking around with no apparent destination

Closed down industrial or business establishments

Nobody to go to if there is a problem (i.e., areas with boarded up homes, closed businesses or industrial firms)

Evidence of drug use or criminal activity

Lots of graffiti

Adults and teenagers loitering on street corners during the day

Prostitutes standing around on corners

Crack vials and syringes on the street

House with lots of people going in and out

Abandoned or boarded up buildings

Unkempt homes: Broken windows, homes in need of extensive repair

Area with many boarded up homes

Many old or abandoned cars

More trash than normal

The appearance of any one of the above characteristics does not mean that an area is unsafe. However, if you notice several of these characteristics, and you have a gut feeling that you should not be in that area, it probably means that the area is unsafe.

B. How to Increase Your Safety

1. Dress casually, in flat shoes, with no jewelry. (A casual watch is fine.)

2. Do not go into a possibly unsafe area alone.

3. Have exact directions to the home. Tell the mother that you are unfamiliar with the area and ask her exactly where to park the car.

4. Arrive early to a neighborhood to check things out. If you give yourself plenty of time then you will be better able to make an evaluation of the area.

5. Carry minimal equipment in a canvas tote.

6. Don't carry a purse.

7. Don't leave anything in your car. If your car has a trunk, try not to keep the equipment in there. If you are seen going into the trunk, someone may suspect that you have other things in the trunk.

8. Look like you know where you are and what you are doing. If you look intimidated, you are more likely to be the target of crime.

9. Make sure that someone knows the time of your visit and the time that you are expected to return.

10. Keep in contact with the local police precinct. They can answer many questions you may have about an unfamiliar area.

11. Try to schedule the home visit during daylight hours.

C. Dealing with Unusual Circumstances From a Safety Perspective

1) If the visitor arrives in front of the house and decides it is too dangerous to get out of the car, or the house looks "too questionable to enter", the visitor should get to the nearest safe phone booth and call the mother to tell her that she is not coming. In cases where the visitor knows that she is going to a

borderline neighborhood, she should arrive early to check out the situation. This way she will also minimally inconvenience the mother because she will call her about the time she should have been arriving rather than leaving the mother waiting. In this case, it may be better not to tell the mother the truth about our fears of her house and neighborhood because this may be inaccurate and unkind. Visitors could tell her that something happened and they couldn't get to her house. Although we did not reschedule when the situation was too dangerous at one month, we will attempt to handle these circumstances differently at 24 months, since this is a longitudinal study. We now have considerable data and time invested in this family. Reschedule the visit and enlist help from security or police personnel to enable you to make the visit on the next try.

If you know from previous visits that the home is in a dangerous neighborhood, you should check out the area at least 48 hours before the scheduled home visit as was done before the 1 month visit. If you see that the neighborhood does not at this time meet the criteria for "safe," make arrangements to have the help of security or police personnel to get from your car to the home and back. If you cannot obtain help to make the visit safely, then cancel the appointment and send the mother a check for $30.

If the visitor enters the house and decides that the situation looks unsafe: If the situation looks extremely unsafe (see safety regulations) as the visitor enters, the visitor should leave and arrange to visit the mother at another time. For the next visit, the visitor will need to arrange security or police protection.

If the visitor enters a situation which appears okay at first but later becomes dangerous, she should leave as soon as she can and as tactfully as possible without compromising her personal safety. As she leaves, she can briefly explain that this looks like a bad time.

If the visitor decides not to see a family on the basis of safety, she should report this to the Study Coordinator and Principal Investigator. In addition, the visitor should document why and how she arrived at the decision to terminate the home visit so that a written justification, based on each site's guidelines, can be sent to the Data Coordinating Center. (See the Safety Exclusion Form, in Appendix D of Chapter 6.1.) Some suggestions on developing site-specific safety guidelines are contained in Appendix G of Chapter 6.1.

VIII. OVERVIEW OF TRAINING

The 24-month training for the home visit will be different from the previous training efforts. For this training, Brian Vaughn, who is a consultant to the Steering Committee for the 24 month Attachment Q-set, will visit each site for a period of 3 days. During those 3 days, he will make home visits with the RAs who will be responsible for completing the 24 month home visits. Training will entail observation of his approach to collecting observational data relevant to the Attachment Q-set and his procedures for sorting the items from the Q-set, after the observation period. He will also observe and adjust as necessary the approach to the observation task and the sorting procedure by the RAs. Training will proceed in four phases (a detailed training plan has been sent to each site):

A. Phase 1: To become acquainted with the Q-set items and the reasons these particular items have been included in the Attachment Q-set, it will be important for the RAs to read several chapters and articles by Mary Ainsworth and associates and by Brian Vaughn and Everett Waters. It would also be useful to a potential observer to have read Bowlby's Attachment volume. At a minimum, the following articles/chapters should have been read and understood during July of 1992. This material will be sent to you in June 1992.

1. Ainsworth, Blehar, Waters, & Wall (1978). Patterns of Attachment. (chapter 7, "Relationships between infant behavior in the strange situation and at home"), Hillsdale, NJ: Erlbaum. (Chapter 1 will also help to orient readers unfamiliar with Ainsworth's perspective; Chapter 8 gives corresponding data relating maternal behavior at home to infant behavior in the strange situation).

2. E. Waters, & K. Deane (1985). Defining and assessing individual differences in attachment relationships: Q-methodology and the organization of behavior in infancy and early childhood. In I. Bretherton & E. Waters (Eds.), Growing points in attachment

theory and research. (Monographs of the Society for Research in Child Development, 50, [Serial No. 209, pp. 41-65]). (This chapter describes the rationale for a Q-set measure and Q-methods in general. Although the item-set you will use is different from the one originally described in this publication, the thematic content of the items is the same in both Q-sets. It is very important that you read and understand this chapter. If there are any questions about it, the will be discussed during training. A second chapter in the same volume of the SRCD Monographs by Vaughn, Deane, & Waters provides additional information about the Q-set and the thematic contents covered by the Q-items. In addition, the first substantive chapter by Bretherton provides an excellent overview of attachment theory and research circa 1985. For RAs without a solid and extended background in attachment research and concepts, this is a good starting point.)

3. B. Vaughn & E. Waters (1990). Attachment behavior at home and in the laboratory: Q-sort observations and strange situation classifications of one-year-olds. Child Development, 61, 1965-1973. (This article provides some evidence that the home observations and Q-sort security scores derived from them are related in predictable ways with the behavior of 12-month -olds seen in the strange situation. Again, the item-set used is not the same one that you will be using for this study, but the points made should be equivalent). There are also a number of other published articles that are relevant and may be of interest

to the RAs and others interested in the training exercise. One of the more provocative is by Waters, Kondo-Ikemura, Posada & Richters (1991). It is a chapter in Volume 24 of the Minnesota Symposium on Child Psychology (M. Gunnar & L.A. Sroufe, Eds.). The title is "Learning to love: Milestones and mechanisms in attachment, identity, and identification."

A number of recent papers have appeared in Child Development in which the Attachment Q-set has been used as an index of attachment for children between 18 and 40 months of age. Several more such papers are in press in the leading developmental psychology journals. All are relevant to the tasks being given the RAs for this collaborative study.

B. Phase 2: After reading and digesting this material, you will be sent a videotaped tutorial on the Q-Set by Brian Vaughn and 2 practice videotapes showing an observation. You will do a practice Q-Sort from watching the videotape and then will see how an expert did the Q-Sort and why. The tutorial and the practice videotapes will arrive August 1, 1992. Then, you should make at least two and not more than five practice home observation on your own prior to Brian's arrival for training. Several observations will be preferable since many questions regarding the Q-set and the Q-sorting procedures will not occur to you unless you have attempted to complete a sort on your own.

All reading and the preliminary home visits should be completed about 7 to 10 days prior to Brian's scheduled visit to your site. The training visits are scheduled between September

1, 1992 and November 20, 1992. It is better not to do the visits more than a month prior to Brian's training visit, since your questions will not be fresh in mind. Thus, sites should time their activities depending on their scheduled training.

Each site should invest in a copy of Q-STAT, which is a computer program developed and marketed by Everett Waters at SUNY-Stony Brook (Stony Brook, NY 11794). This program is inexpensive (about $75) and provides excellent utilities for entry of Q-sorted data. The program is especially helpful for training purposes as it can identify items or sets of items sorted differently by two observers. The program also provides a convenient way to calculate criterion scores and includes a copy of the current criterion Q-sort for Attachment Security. It is well worth the money and can save time and headaches often encountered when attempting to decode and score Q-sort data.

B. Phase 2: When Brian arrives at each site, it is expected that at least three home visits will have been scheduled, along with three backup cases in the event that a scheduled visit is canceled or doesn't work out for some other reason (schedule more if several observers must be trained). For the purposes of training, it is best that the three home visits be scheduled on separate days. However, it may be necessary to complete two home visits on day 2 of the training. This will be dictated by the availability of appropriate pilot cases and by local plane schedules for getting in and out of your site. Ideally, the schedule will be as follows:1. Day 1: In the morning, Brian will meet RAs and others being trained. After a brief overview of the Q-set and Q-methodology, questions and problems that have come up in practice, pre-training cases will be identified and resolved (to the extent such questions/problems are resolvable). Questions about the sort itself will be discussed. (All questions asked of Brian and the answers given during training at each site will be tape recorded, transcribed, and compiled as an appendix to this manual.) And, finally. a consensus sort of the "ideal 24-month old" will be completed and discussed.

Day 1: In the afternoon, Brian and the RA trainee(s) will make the first home visit. It is expected that the subject will have been fully informed as to the number of adults coming on the visit, that the purpose of the visit is to learn how this instrument is used, etc. By and large, the trainees will stay close to the child, making brief notes of the moment-to-moment behavior of the child, especially as her/his behavior is relevant to Q-set content domains. You should have a copy of the item set with you (but not as separate "cards") so that you can refer to it over the course of the home visit. You will be especially careful to inquire from the mother about attachment content that is not observed in the first 90-100 minutes of the visit.

Taking notes during the home visit is a very idiosyncratic process. For some observers, it is important to have a continuous running record of the child's behavior. For others, very sketchy and minimal notes are more than adequate. As a rule of thumb, it is usually helpful to have a minimum of a page of handwritten notes for each 30 to 45 minutes of observation. In a two to three hour period, you should expect to take 4-6 pages of notes at the very minimum. Persons with tiny cursive habits will have proportionately fewer pages of notes. Remember, these notes are to help you recall the behavior of the child when it comes time to sort the Q-items. The more, and more relevant, detail you have, the better the notes will help you. The notes will be especially important if you are forced to postpone completing the Q-sort for several hours after the home visit. (In general, you will want to sort the Q-items as quickly as possible after the home visit. In this case, extensive notes may not be as critical. However, even when the sorting is completed immediately after the visit, good notes can make your task much less onerous.)

After the visit, the RA trainees and Brian Vaughn will review the notes taken by RAs and then complete the Q-sort. There are many different procedures that can be followed in completing a Q-sort. Over several years and with hundreds of children the following procedure has proven quite useful.

First, the 90 items of the Q-set are divided into three roughly equal stacks or piles. In the first stack are items that are UNCHARACTERISTIC of the child, or are OPPOSITE what the child was like during the home visit. In the second stack are placed items that are MOST CHARACTERISTIC of the child. These are the items from the set that are most closely like the child as you saw her/him today. In the third stack are placed items that are

BOTH LIKE AND NOT LIKE the child. Some items seem to characterize the child at one point in the visit, but not at other points. These items would be placed in this third stack. Other items were not observed one way or the other. If you have no information upon which to base a judgment for a given item, this item should be placed in this third stack. Some of this content might have been discussed by the mother, upon probing questions made by the observer, but if relevant behavior is not directly observed during the visit, then the item should be placed (initially at least) in this stack.

Now, you have three stacks or piles of item statements (those items Characteristic of the child, those items neither characteristic nor uncharacteristic, and those items Uncharacteristic of the child). Each of these stacks will be further subdivided into 3 stacks, for a total of 9 categories.

Starting with the item seen as MOST CHARACTERISTIC, divide these into three separate stacks. In the first stack, place those items that are really the MOST CHARACTERISTIC of the child. In the second stack place those items that do not quite make it into the MOST CHARACTERISTIC pile. Place the remaining items in the third stack. Now adjust the numbers of items in each stack to the predetermined distribution for your study. For this study, we have elected to use a quasi-normal distribution of items (4, 6, 10, 15, 20, 15, 10, 6, 4), make sure that the numbers of items in each category conform to the chosen distribution. If there are items remaining in your stack after making the appropriate adjustments, place them in the stack containing "Neither characteristic nor Uncharacteristic" items.

By convention, the 4 items "Most Characteristic" of a case are assigned to Category 9, the 6 items considered next Most Characteristic items are assigned to Category 8, and so on. You will now have completed the Q-sort for categories 7, 8, and 9. You should have 10 items in Category 7, 6 items in category 8, and 4 items in category 9.

Now, take the stack of items seen as "UNCHARACTERISTIC" of this child. Go through the same exercise as described above. That is, subdivide the stack into three piles and rearrange items in each stack until you have obtained the prescribed quasi-normal distribution. If there are items left over, place them in the remaining large stack of "Neither Characteristic nor Uncharacteristic" items.

By convention, items in the "MOST UNCHARACTERISTIC" stack are assigned to Category 1, the next Most Uncharacteristic items are assigned to Category 2, and so on. You should have 4 items in category 1, 6 items in category 2, and 10 items in category 3. When this part of the sort is completed, you will have items/cards placed in six stacks (Categories 1, 2, 3, 7, 8, 9).

Now return to the final stack of items. These are to be divided into three piles, as with the Characteristic and Uncharacteristic items. The most neutral or non-descriptive (not UNdescriptive) items go into the middle category with items falling on either side being SOMEWHAT undescriptive or descriptive of the subject. Arrange items into the final stacks according to the quasi-normal distribution prescribed. These items will be assigned category scores of 4, 5, and 6. There should be 15 items in category 4, 20 items in category 5, and 15 items in category 6.

When you have completed the sort this far, arrange the items in order of categories (from 1 to 9). Look over the items in each category and feel free to change your mind about the placement of specific items, if you realize that certain of the item meanings is more or less characteristic of the subject than implied by its initial category placement. If you are satisfied that the item placements provide the best description of the child at this visit, enter the category scores onto the Q-sort score sheet. Or, when you are practicing, use Q-STAT to enter the data, if you have access to a computer when the sort is completed.

After the sort is completed by consensus among the RA trainees and Brian Vaughn, further questions and problems that have come up will be identified, discussed and resolved (or put off for the next day).

2. Day 2: The second home visit should be scheduled for the morning of the second training day. The visit will proceed as for training day 1. Again, the RA trainee should plan on spending the bulk of time close to and observing the child for at least the first 90-100 minutes of the observation period. In the

last 20-30 minutes, the RA trainee will complete the interview aspect of the observation with the mother.

After the visit, notes taken during the visit will be reviewed and critiqued. The sort will be completed as on day 1.

In the afternoon, the two cases observed will be compared and contrasted. The two sorts of the children will be compared and a discussion of the cases will focus on the differences seen between the children. To the extent that differences may be a function of differences in the setting, time of day, and other attachment irrelevant aspects, these will be identified and their implications discussed.

As an emergency contingency, when the home visit on day one was not completed as scheduled, or when plane connections make it impossible for a third visit to be completed and discussed on training day 3, a second home visit will be scheduled for the afternoon of training day 2. In this case, the discussion of all cases will take place the following morning.

3. Day 3: It is expected that the third home visit will take place in the morning, with the RA trainee taking full responsibility for conducting the visit. Brian Vaughn will simply serve the role of evaluator, not a second observer for this visit. Again, the RA trainee will spend the bulk of time near the child, with about 20-30 minutes at the close of the observation spent taking information about content domains under observed (or not observed at all) from the mother.

After the observation visit, the RA trainee and Brian Vaughn will review the RA trainee's notes and then complete the Q-sort independently, according to the prescribed distribution. The sort will be discussed and critiqued by the RA trainees and by the evaluator. Rater agreement between the RA trainee and Brian Vaughn will be assessed in terms of the Q-correlation between the two independently formulated Q-sorts and in terms of the number of items sorted more than 2 categories apart. For purposes of determining rater agreement, Q-correlations between .55 and .65 are acceptable. In addition, it is anticipated that no more than 9 items would be sorted more than 2 categories apart by the observer-pair.

C. Phase 3: Rater reliability and rater agreement over time. Although all RA trainees will have achieved an acceptable Q-correlation at the time of initial training, this does not necessarily insure valid and reliable observations throughout the period of the project. Two weeks after Brian's training visit to a particular site, that site will be sent 5 videotaped observations for certifying observers. Observers will independently view the 2-hour videotapes of children in their home environment doing one videotape per day. After viewing the videotape, they will complete a Q-Sort based on the videotape. These Q-Sorts will be recorded on the Q-Set form and sent to the Data center. The observers will "pass" if their median agreement with an "expert" is 60% with no test tape lower than 40%. There also may be a criterion for the accuracy of placement of individual items.

At two other points, after the third and seventh months of collection (weeks of April 12th and August 16th, 1993), the observer will be sent 3 videotaped observations to check for drift.

Previous experience with the Q-set suggests that reliability and validity of the Q-sorts is enhanced when observers complete the sorts immediately after the home visits, rather than hours or days later. Validity will also be enhanced to the extent that the home visits are as "standard" as possible across all subjects. Close attention should be paid to those conditions identified above that would lead the observer to reschedule the home visit. The mother should also be asked directly about the "typicalness" of her child's behavior during the home visit. If she reports marked atypicality, the Q-sort data must be considered suspect.

A subset of cases observed simultaneously by two or more Q-sorters will also be used to establish and maintain rater agreement/reliability. At least 6 observations should be done jointly by each pair of observers. These observations should be spread throughout the data collection period. Q-correlations of at least .60 will be considered acceptable. If the Q-correlations move below .60 for observer-pairs, then additional joint visits would be in order. At the conclusions of these visits and after completing the sorts on the subjects, the observers should compare and share notes and discuss the child's behavior and the child's interaction with the mother. Focused discussion and sharing of notes can increase the degree of rater agreement over time and can help calibrate raters to each other.

24-MONTH HOME VISIT ADDENDUM
TROUBLE SHOOTING

I. PURPOSE OF THIS DOCUMENT

Due to the diversity of both families and Research Assistants participating in the 24-Month Home Visit (Q-Sort) across ten sites, there will be areas in which "trouble shooting" is required. The following section contains information about areas in which potential problems may arise with appropriate responses given for these situations. Thanks to Brian Vaughn and German Posada for working with us on answering many of your queries. Many of the answers provided are transcribed from an audiotaped response they have given. This is a working document. We will be updating it throughout the 24-month data collection period. I encourage you to send me (or call with) your questions as they arise. Also, speak with your PI and Site Coordinator as problems occur and let me know any decisions made at your site that might be helpful to include in future revisions of this document.

II. PROBLEMS DURING THE VISIT

A. Mother and child sit together and play the entire 2 hours

What should be done if the mother and child sit together and play (do not separate) during the visit? This makes it difficult to sort many of the items, as was the case in the Austintest tape. Should the RA ask the mother to do something that requires her to go to another room?

Brian's Response: If the mother and child have 45 minutes in play and it looks like they will not stop, have RA's ask if this is what mother and child would do under ordinary circumstances (like if RA was not there). If mother says "yes, this is what we always do" then I would try to reschedule at some time when they have more variety in their time together. If mother is adamant about never doing anything but sitting and playing with child, then accept that you will get no better observations and sort from what you see.

This is not optimal since you see no separations, no child playing alone, etc. In this case (when rescheduling is not possible), lots of questions will need to be asked. You should try to get the mother to play more chase or hide and seek games. Asking the mother to go do something else seems undesirable if it seems clear that the mother is only staying with the child "so you will see some interaction".

One way you might avoid this problem is in the scheduling. If mothers are asked what kinds of activities they might do when the observers come, they can be assured that observers are not there only to watch mother-child play and that mothers should feel free (obligated) to do whatever chores, child maintenance, and play that they might otherwise do. If mothers volunteer that they play for 2 hours when they get home, try to schedule another time.

B. Other family members are present

It is extremely important during the scheduling phone call, as well as the visit confirmation call, to emphasize to the mother that this visit requires that only mother and target child are present (younger sibling/s are okay). Read carefully the information concerning "others present" in section C. Pre-Visit Preparation (pages 12-15, chapter 22).

III. A SECOND VISIT

A. When is a second visit necessary?

Many of you have asked this question. We have provided a good bit of information concerning this in the most recent version (1-14-93, Chapter 22) of the 24-Month Home Visit Manual. Read carefully section D. Rescheduling, on pages 16-18 and the end of section E, particularly pages 26-27. In order to determine when a second visit is necessary, good clinical judgment must be used. A second visit may be required due to the following circumstances:

1) At the end of the 2-3 hour period you do not feel confident that you have enough information to do the Q-Sort. One or more of these things may have occurred.
    A) many interruptions
    B) the child went to sleep
    C) there were others present
    D) it was an unusual or difficult visit in some way
    E) child watched television/video for most of the visit

2) The mother indicates that the child's behavior was very atypical.
    A) child was becoming ill
    B) child very distressed

3) During the Post Home Visit Interview, the mother may tell you that something very difficult has happened to her today. You feel that her behavior during the visit was highly atypical, therefore the child's interactions with her were likely to be affected as well.

4) There are a large number of items that you have not observed (more than 30 or 40). Or, you do not have a sense of the items that you will place in the top 2 and bottom 2 piles.

Again, read carefully the information about rescheduling (pages 16-18) and what you need to say to the mother if it is necessary to reschedule or to lengthen the visit (page 27).

IV. Q-SET ITEM CLARIFICATION

Many of you have asked questions concerning the interpretation of various q-set items. In this section we will answer many of those questions. It is impossible to consider every situation in which a particular item might be in question. Remember, good clinical judgment must be used. Most important, you should consider the saliency of the behavior expressed in each item WITHIN THE CONTEXT OF THE ENTIRE VISIT. We are looking for those behaviors (items) that are most salient for the child over the course of the visit. These items are to be sorted as most characteristic (7, 8, or 9) or, they are to be sorted as uncharacteristic 1, 2, or 3) if the behavior described as "low" is very salient for the child within the context of the entire visit.

A. General Issues and General Questions

1) Items sorted to the middle (4, 5, or 6)

Items can be sorted to the middle for various reasons. **First**, an item may be sorted to the middle if the behavior is both like and not like the child. Some items seem to characterize the child at one point in the visit, but not at other points. **Secondly**, you should place an item in the middle stack if you have no information upon which to base a judgment for that particular item. Some of this content might be discussed by the mother, upon probing questions made by the observer, but if relevant behavior is not directly observed during the visit, then the item should be placed (initially at least) in the middle stack. **Thirdly**, an item should be placed in the middle if the child's behavior is best described by a "middle" description given on the item card. A separately defined middle description is given only for the following items: #s 12, 13, 21, 22, 25, 27, 28, 34, 35, 49, 51, 60, 61, 69, 77, & 90.

Items can be sorted to the middle for any of these three reasons. For those items with a "middle" description given, IT IS NOT NECESSARY FOR THE CHILD'S BEHAVIOR TO MATCH THE MIDDLE DESCRIPTION TO SORT THE ITEM TO THIS PILE. The item can be placed in the middle pile due to reasons one and two as well. For example, let's look at item # 12

"Child quickly gets used to people or things that initially made him shy or frightened him.
(**Middle if never shy or afraid)"

During the course of your visit you might note that the child quickly becomes used to you even though he had initially hidden behind his mother when you came to the door. You later note that he seems to remain afraid of the plumber who comes to repair the leaky faucet. Therefore, you sort this item to the middle because you have observed one case of this being characteristic for the child and one case of it being uncharacteristic, even though it doesn't match the "middle" definition given.

German Posada's comments:

I've read some of the comments sent to Martha by Brian Vaughn as to why some items wind up in the middle piles. I also agree with Brian. He and I had gone over every single item in the Q-sort and we commented about each of them and what we said, basically, was that some items, for one reason or another, in this 2-year-old project, wind up towards the middle. I guess when Brian went to each of the sites he must have mentioned something related to this. As a result, some observers may have felt that certain items should automatically end up in middle piles. Which is not what Brian meant and is not what the Q-sort should do.

In other words, if we think of the Q-sort items as descriptors of child behavior that we're going to use to characterize a child, before we characterize the child, before we observe the child, before we start doing the Q-sort, all the items should begin being placed in the middle. We use the visit and the information obtained in the visit as the basis for moving items away from the middle.

For most of the items, or for a lot of them, we're going to find information about them. And then, we're going to start moving them toward the characteristic side or uncharacteristic side. Some items we won't obtain information for, so they wind up in the middle. Some of the items we will obtain information for, but that information basically tells us to put the item in the middle. I don't really move an item from the middle more than one pile (only in very extreme cases, when I don't have enough items for pile seven, or going down to pile three, I'll move an item to one of those piles) because of mother's information, very rarely. I don't think that I did it more than once or twice in these instances. So generally, mother's information just helps me to move items from five to six or from five to four, for example. The reason is that sometimes mothers tell you something and then you observe quite a different thing.

So in any case, this is just a different way of saying what Martha and Chris have explained as to when an item goes in the middle.

2) Visitor's Interactions with the Mother

Tell mother at the beginning of the visit that our goal is to be like flies on the wall. We want to observe the child and be minimally interactive during the first part of the visit.

3) Visitor's Interactions with the Child

Use the child behavior as a cue for how much interaction you will have with him. If the child is shy when you arrive, do not approach him immediately. Follow his lead. You must consider the child's initial reaction to you as well as his general nature in determining how quickly you will approach him as well as how quickly you will try to elicit particular items on Q-set items (e.g. #15, 48, 72, 78). Brian suggests that you use a natural opportunity to pick-up the child during the course of the visit. The child may come to you for comfort or assistance. More likely, you will have to find a situation when the mother calls to the child from another room, then you can scoop him up and carry him in. Also, asking the child for "high five" as you leave seems to elicit various reactions.

Some children may be so totally caught up with interact- ing with you that can't see many behaviors relating to mother/child interactions. Brian suggests that after 20 minutes of this you leave the room and go into the other room with the mother and begin asking her some of the questions.

4) Saliency or frequency?

You count both, but basically, there are a series of things in these items, behaviors that are very low frequency and they could be very salient. And they just need to occur once or twice and they could go as high as nine without any problem, if it is very salient. That's one of the characteristics of the Q-sort method. That not just frequency counts. Unless the item is made for that purpose.

5) Timing of the observation.

Do we begin timing two and a half hours from the minute we enter the home? Will it differ depending on whether there are people present who we need to get rid of before beginning the observation? Even when you're not ready to start doing the observations, there are some items that need to be checked at the very moment you get there. So you should pay attention to some things that happen immediately after you walk in.

6) General Questions

1) To what degree can the placement of an observed item be moved by the maternal report when doing the sort? If the observation of an item contradicts the mother's report, where should this item be placed?

Answer: You should give more weight to what you actually observe during the visit.

2) How do we handle the situation when the child is watching too much TV during the visit? I think that we've addressed this question, too, but in any case, let me say that the deal thing would be that he not watch a lot of TV during the visit, because it doesn't allow him to interact with anybody. And as a matter of fact, I recall we had an experience here at Stony Brook. Once we basically had to redo a visit because a child spent an hour in front of the TV and he would barely talk to anybody. So I guess the ideal thing is just to try to get him off the TV, or get the mother to get him off the TV. But it depends on each case. Sometimes it's not possible to do that.

3) **How much do we direct activities in the course of two hours?** I think that this question was addressed in the rationale by Martha and Chris. I guess you would try not to be that influential in that we just want to see interactions and what goes on in each of these family homes, as they occur naturally. So we try not to influence. On the other hand, if we need to interact, we interact. **When do we need to influence what's going on?** It occurs to me that maybe this question has to do with the fact that some people going into the visits may feel a little bit uncomfortable about what to do in the visit. For me, the best thing is just to go to the visit, just act like a regular person, without really interfering too much. If people talk to you, you answer back. We have to introduce some activities like the snack and the book. So those are ways of influencing things when observers are going to ask questions. I think that these things have to do more with the observers getting used to the visits and just feeling at ease during them.

4) **Regarding the mom's report, are there some answers that you give more weight to?** Well, no, it depends on how specific and how clear an answer is. But again, since the mother's answers are not going to give us the most or the least characteristic items, it's really not that crucial.

5) **Why do you ask the mother about items that are going to wind up towards the middle anyway?** You have to make some distinctions about the items in the middle. You have to find items for six, five and four. So that's why. But true, I mean, this is not going to change your placement much. But we do need to make those distinctions by asking the questions. And sometimes the mother's answers clarify behaviors that are not totally clear during the visit. So I think that questioning the mother can be used in different ways and is necessary.

6) **How do you sort data that is not exhibited vs. data that is uncharacteristic?** I don't know if this is a matter of one versus the other. Sometimes not being exhibited doesn't mean that in goes in the uncharacteristic piles. In other words, I think that there are two parts to this question. My interpretation of the question is that sometimes we don't have information about some items. That doesn't mean that it's

uncharacteristic. Chris and Martha have addressed this; that it should go in the middle. Now, not being exhibited may sometimes mean that it goes into the uncharacteristic side. For instance, the item about being fond of adults (#66). This is an example. The low end sometimes is determined in part by lack of evidence as to the child's being fond of adults; in other words, the child doesn't seem to care whether you leave, doesn't seem to be very affectionate, or this type of behavior. When he doesn't exhibit it in spite of your having interacted with the child or having been there for two hours, then it gives you an indication that probably, he doesn't do it. But again, being not exhibited cannot be confused in every single instance with not having information about an item. Those things are different.

7) **What is the norm for "neat and tidy" for two-year-olds?** One important thing about the Q-sort is that it tries to eliminate the roles of "norms" that observers bring into their descriptions, by asking them to compare the behavior of one child by himself. In other words, the behavior of one person. You're not comparing one person with another one. I know what you're trying to ask but what I'm trying to say here is you just have to look for information that says the child is clean and tidy or attempts to be, makes an effort to be clean and tidy.

8) **How do you determine if he is strongly attached to new items?** The first thing is that I wouldn't call it "attached". But I think the person here is talking about #40. How do you determine whether the child really gets into the activity; with the book in this case or with any new object? See whether he really engages with the new object or whether he just takes a look and throws it out and keeps on doing some other things he was doing before, or goes onto other familiar activities.

9) **How can you tell if a child is bored?** Well, I guess, as Martha and Chris have said, people have to use, on occasion, some kind of judgment on some of these items. And sometimes the child is not very enthused, he doesn't engage very much in his activities, or he just wanders around. That's what it means, being bored. I know that is very difficult to see, but I guess that's what being bored means.

10) **Observed vs. asked items**

Question: What percentage of items can we ask the mother about, rather than observe, so that the Q-sort data is still considered reliable? Similarly, at what point do we decide that a second visit is warranted?

Answer: This issue is covered in the 24-month home manu-`al. Brian also indicated that he generally asks about 20 to 30 questions during the course of the visit, but many of these are clarification probes regarding behaviors he has already observed. As stated in the manual, if you must ask about 30 to 40 of the items (because you haven't observed them), then the visit should be redone.

11) How to best ask the mother questions

You will ask the mother questions for two reasons: 1) to probe for clarification about behaviors you have observed during the visit and 2) to ask about items that you have not observed during the visit.

When probing, use the content of the visit and go from there. For example, item 16: child prefers toys that are modeled after living things (e.g. dolls, stuffed animals). The observer might say to the mom (after observing the behavior) "I noticed that Ashlyn enjoys her Barbie dolls and stuffed dog a lot, does she seem to prefer these to her blocks and legos?"

When asking questions you are wanting the mother to focus on current (contemporary) behaviors. Try not to read the items verbatim. Don't ask leading questions.

12) Do observers count as visitors, people other than mother, new adults? Yes, we are the visitors. We are the people other than mother. We are the new adults for those two hours. Yes, the only way of doing those items in which new adults or visitors are included is just by basing our observations on the child's behavior regarding us.

II. Questions about specific items:

Question: Item # 1: Does the mother have to ask the child to share? Posada looks at give and take in play and counts that as sharing.

Answer: Item # 1 says "child readily shares with mother or lets her hold things if she asks to". The mother does not have to ask the child to share, it says or. Observed give and take also counts as you have noted in the Posada scoring. Place in the middle if the mother never asks and the child never shares.

Question: Item #2: What does "returns to mother after playing" mean, does it mean returns to mother after being in a separate room.

Answer: The child doesn't have to have been in a separate room, it can be just returning and checking in with mom from an activity across the room.

Question: Item # 3: If we have mom's report that child accepts comfort from others we tend to see this as a six. Posada tends to ignore mom's report and consistently scores low because child goes only to mom. It seems to us we would never see a child go to a stranger (the visitor) for comfort but that is not enough reason to score low.

Answer: You should always use observed behavior as a stronger indicator of where to place the item over responses from the mother to questions about the item. It is possible for a child to come to the visitor for comfort. In fact, if you are near the child when the child hurts him/herself you can say something like "Oh, did you hurt yourself? Let me see." to see if the child will come to you. Generally, this question is one that you should ask the mother about even if you have observed it. But if you observe the child going directly to the mother when upset or injured and showing no inclination to come to you, you should place the item toward the low end even if the mother reports that the child will go to others.

Question: Item # 5: This item has been confusing to people in terms of knowing how to rate television and children's attention to toys when he is in proximity to people.

Answer: Brian has suggested apparently that the easiest way to see this is if all the adults leave and room and then see whether the child continues to play with toys or watch TV (prefers things) or whether he follows the adults. But even when the child and adults are in the same room, you can look at the way the child distributes her/his attention. Does she focus on her toys and show no interest in the adults or does she look at/talk to/listen to the people around her? Even if he/she is playing with toys are his/her interactions with people in the service of his/her play with things or do the social interactions seem to be the most important?

Question: Item # 7: Posada seems to ignore the definition for low on this item. He scores high if he observes them smiling.

Answer: We can't figure out this criticism. Posada seems very clear in his use of this item. Note on Megan, he places the item low (3 or 4) because he says that even though the child smiles with everyone, the mother can get her to smile more easily. Please go over Posada's justification of the placement of this item for the first 5 test tapes; his rationale seems quite clear and consistent.

#8) When child cries, he cries hard. Low end, weeps, sobs, doesn't cry hard or hard crying never lasts very long. I think that "cries hard" refers to the fact that there are children who, when crying, are loud in doing it. The only sort of confusion, I think, arises from the fact that the low end says hard crying never lasts very long. This clearly refers to the duration of hard crying. Crying hard means that the child cries loud. I don't know how to explain it in a different way. Probably, some of the observers, and that's good, are trying to be very literal about the item. They want to exactly discriminate when the cry becomes hard crying and when it becomes soft crying. It just means simply, for me, that some children really scream and are loud about their crying, and some others just sob, weep, their crying doesn't last very long.

Question: Item # 10: Brian says ask mom. Posada puts in the middle always because he says we never see.

Answer: What do you see as the contradiction here? Please note the reasons for placing items in the middle (both in the manual and earlier in this troubleshooting section). You place items in the middle if you don't see it and can only ask about it. Posada places the item in the middle because he says we never see it. Brian is correct, you should still ask the mother even though we never see it and then you can decide whether to put it at a 4, 5, or 6. They are both correct, and there is essentially no disagreement here.

Item#11 and Item #44. Having to do with child often hugging or cuddling against mother without her asking or inviting him to do so; and child enjoys having mother hug, hold and cuddle him. These items seem very similar because it seems the child will often initiate a hug by asking for a hug. What should we look for to distinguish the scoring of these two items? Also, in #44, does asking for a hug always have to be a verbal request? Asking for a hug doesn't have to be a verbal request. It could be just lifting his arms and just going for a hug, to be picked up. Now, the items are very similar. And I think that #11 focuses more, in this case, on frequency. Whether the child just frequently goes and hugs and cuddles against the mother. #44 has to do more with the child asking for and enjoying these behaviors. So I agree, they're very similar. Yet, they're not exactly the same.

Question: Item # 12: Define quickly. Item # 12: Child quickly gets used to people or things that initially made him shy or frightened him. (Middle if never shy or afraid).**

Answer: Quickly means 5 to 10 minutes. This also counts for child's reaction to seeing you (visitor).

#12) See rationale given by Martha and Chris. NOTE: Each of these by themselves are not that important; what I'm trying to say is that the placement of an item also depends on other items. In other words, how salient the item is in this pool of items. So a child could be quick to warm up to strangers but it's not that salient because there are some other things that call your attention, that are more visible in this particular child.

Question: In Items # 14, and 40 does "new" refer to something truly new to the child or can it be a different activity?

Answer: "New" means totally new, not just something different. Use the book vignette to sort these items. Rarely will a new toy show up during the course of the visit. But if it does (as in the Jacob tape), certainly use this information.

Item #15. If the child talks to new people, shows toys, etc., would you move lower if the mother didn't ask him to? This item looks at behavior in the context of the mother's asking the child to do something. So I consider that, basically, what I'm looking for. If the mother doesn't ask but the child shows or talks to new people, even in the presence of the mother, that's some kind of indication. So I don't see any problems. But it is much more clear if the child does it when the mother asks. In some instances, the mother does that, so it's much clearer.

#16) Child prefers toys that are modeled after living things; dolls, stuffed animals. Low, prefers balls, blocks, pots and pans. Her question has to do with the fact that ah, what should we do if a child, say a little girl, has only dolls and stuffed animals? Well, if that's the case, I think that one has to look at how the child plays with these toys. If there is no opportunity to see whether she has balls, blocks, pots and pans, then we don't really have any information about this thing. Yet the fact that she plays and has these other toys, if she indeed plays with them, would give you a bit of information. But then in that case, I guess, if you're not sure, you don't place the item very high, and certainly not toward the low end, because you don't know. And you may get some information from the mother that would help you a little bit in this case. But again, if you don't have the information you cannot just place the item in a very extreme pile.

Item#18. According to Brian, this item implies that the mother is already directing the activity. Posada scores according to whether the child follows suggestions, whether they are already directing the activity or not. I don't think that what Brian has said and what I do is much different. It doesn't really have to redirect activity, as long as the child follows mother's suggestions, it applies to the item. It doesn't have to be exclusively redirecting activity.

Item#21. Needs clarification on "keeping track". Posada tends to score higher than Brian's instructions would indicate. Brian says we are not really in the home long enough to see this clear- ly.

The item reads: Child keeps track of mother's location when he plays around the house, calls to her now and then, notices her go from room to room, notices if she changes activities. Well, that's what keeping track means. I mean, the most obvious way is when the child calls the mother to know where she is. It doesn't have to be an open question such as "mom, where are you?" As a matter of fact, two year olds won't do that. But in any case, and I think that I did this in some of my rationales, things like when the mother moved away from the place she was, the child took a quick look. That's keeping track of mother's location. Sometimes in real visits you can observe the child paying attention to noises. For example, I remember this visit in which I was playing with this three year old and we heard noise in the kitchen. The child immediately, sort of for a second, stopped and was registering that noise. That's what we mean by keeping track. The child is attentive to where the mother is. And if she changes activities, then he either by looking at her or checking her or by hearing and paying attention to noises, real- izes where the mother is.

Item #24. When mother speaks firmly or raises her voice at him, child becomes upset, sorry or ashamed about displeasing her. Do not score high if child is simply upset by the raised voice or is afraid of getting punished. How do we distinguish whether the child is simply upset by the raised voice or is ashamed about displeasing her? I guess the way to make this distinction is by the child's subsequent behavior after the mother has raised her voice and spoken firmly to the child. Some children tend to sort of make up or just, you'll see them upset because of what the mother just said to them. And some of them will try even to approach the mother. Some others apparently don't care and ah, the raised voice doesn't seem to affect them at all, to upset them. So when this happens this goes in the low end. The other part of the question is what happens with the clarification in the item when it says "do not score high if child is simply upset by the raised voice or afraid of getting punished." What the item is trying to do with this clarification is just to avoid mixing together those children who are really upset about dis- pleasing mom and those who are really upset because they may get punished. And these children that get upset, more because of the possible consequences of their behavior, won't do the same type of things after the mother has spoken firmly to them, as the children who are really upset. Like they would just go back without any problems or without checking on mother or without trying to make up for what they had just done. This is a diffi- cult item, I admit. I don't see it happening very frequently. And it's an item in which you have to use some kind of, if you will, clinical judgment. You have to use your judgment to see if the child was ashamed, or wasn't, and more important, whether the child was upset because he had displeased his mother or because he was afraid of getting punished. But again, I think that what determines whether the child was upset and why he was upset is subsequent behavior.

Item#25. This item says "child is easy for mother to lose track of when he's playing out of her sight. Low, talks and calls when out of sight, easy to find, easy to keep track of what he's playing with." I think the item is clear, yet, I think that this refers to the fact that some children, when playing out of sight, are very silent and very quiet and they sort of disappear. The only way the mother could know where they are or what they're doing is when they have to go and check and really look for the child and see what he's doing. The low end refers basically to children who, when playing, they laugh, they talk, they make noises. So those children are easy to keep track of. That's what the item means.

One of the questions is whether "talks and calls when out of sight" refers to child or to mother. It refers to child. "Easy to find" simply means that the child makes noises and is easy to track down, to know what he's doing. **Then the question: If a mom says she can keep track of the child because she can hear him talking to himself or to toys, can recognize the noises of the items he's playing with, is that scored low?** What I would have to say here is that if the mother says that, that's a different thing. The observer has to see this thing. If the observer sees this type of behavior, then yes, they have to score it low. It's not if the mother says. But if that happens, then yes, the child should be described with the low end, which is "easy to keep track of". **And then: "What about the mother whose child is out of sight and completely quiet?"** Well, probably this child is not that easy to track down or to know what he's playing with or what he's doing. And if you want to do that, then the mother has to really go and see and check what he's doing. So probably, I would say, then, the child is easy for the mother to lose track of when the child is playing out of her sight.

Item #26. We've dealt with this, but the question is somewhat different. **Child cries when mother leaves him at home with babysitter, father or grandparent. What if the child cries when left with babysitter but not the father? Does this pertain only to the child's reaction to the person he is left with regularly?** Okay, some items go in the middle because you don't have information, because you're not sure. And sometimes because the child does things from both ends. I mean, in this case, if the child doesn't cry with the babysitter and cries with the father when left with the father, or vice versa, then it'll go toward the middle. I mean, he doesn't cry with some and he does cry with some others.

Item #27. Child laughs when mother teases him. What do we count as teasing? Oh, boy. Well, I don't know how to define teasing but I know that it refers to things like when the mother is playing with the child and she says, or when he's interacting with her and she says, "you silly goose" or she hides from him or she takes things away from him in a playful way. And ah, the child, some children get angry, some children don't laugh and they get irritated. Some children laugh and go with it. So, that's what it means. I hope this is clear.

Question: Item # 28 Child enjoys relaxing in mother's lap. Can this also be leaning against mom when on sofa, etc.

Answer: Yes, Brain says that any leaning, reclining against mom in a relaxing way can be counted. It doesn't just have to be in her lap. Use the book vignette for a good indication of this item.

Item #32. When mother says "no" or punishes the child, he stops misbehaving, at least at that time; doesn't have to be told twice. If the mother never punishes the child or restricts his activities, does this item go in the middle? Yep. Either mother never says "no" or never punishes the child in front of the observers, then you don't have information about the item and it goes in the middle.

Item#33. Brian says this refers to picking up for comfort or distress. Posada scores based on any picking up. The item says: Child sometimes signals to be put down but then fusses to be picked right back up. Generally these things happen when the child is in some discomfort. But it doesn't necessarily have to be when the child is in distress. Yet, it happens sometimes when the child is, and it counts when the child is distressed. But my interpretation of the item is that it doesn't necessarily have to be when the child is distressed.

Item#34. Does this mean leaving the child at home when mother goes out or mother's leaving the room? The item says: When child is upset about mother's leaving him, he sits right where he is and cries, doesn't go after her; low, actively goes after her if he's upset or crying. If I'm not wrong, there is an item also for when the mother leaves home, item #26. Also, item #75, which refers to child's getting upset when mother leaves the room. So item #34 is different from these two and refers to whether the child sits where he is or whether he follows the mother, when the child is upset about mother's leaving him. You should look at this either when the mother leaves the room or when the mother leaves home. What happens is that during the visit, the mother very rarely leaves the house so the only basis we have to judge this thing is whether the child is upset by mother leaving him; he runs after mother or he doesn't. So, I think that it counts for both occasions. That's the way I interpret the item.

Item #35. Does Posada see this as "prefers to play on his own"

being important. Brian focused on "leaves mother easily when he wants to play". Item #35 says: Child is independent with mother, prefers to play on his own, leaves mother easily when he wants to play; low, prefers playing with or near mother. I think that those two things are just expressions, or hints, about the child's being independent or not. Some children just prefer to be on their own, others, when they want to play, just leave the mother. Probably, you should count both of them. That's the way I look at that.

Item #36. Needs clarification on "keeping track". Brian says that this item tends to stay in the middle because in two hours you probably won't see this pattern clearly. Posada based it on the two hours of the visit and sorted it high on Austin. Well, I think that Brian explained this already. This is about secure base behavior. The child clearly shows a pattern of using mother as a base from which to explore. If the child shows it, you score it, either way. I mean, if the child is always close to the mother or always very far away from her, it's showing something. But if you can't see it at all and if you can't make up your mind, you can't judge it.

Question: Item # 37 Child is very active. Always moving around. Prefers active games to quiet ones. What is considered very active?

Answer: You must consider two things. First, how active is the child compared to other two year olds? But of most importance, how salient is the child's high activity level or low activity level in the context of the entire visit and all of the other items. CHILDREN DISPLAYING SIMILAR ACTIVITY LEVELS MAY BE SORTED DIFFERENTLY BECAUSE ACTIVITY MAY BE MORE SALIENT FOR ONE CHILD IN RELATION TO ALL THE OTHER ITEMS THAN FOR ANOTHER CHILD.

Item#40. Since the book is the only new object there will be, can it be rated high if the child is really into it but doesn't use it in different ways or take it apart? The item says: Child examines new objects or toys in great detail. Well I think that the answer lies in the question itself. If the child is really interested, probably, he or she will examine the book, will want to get into it, flip through the pages, look at it. So that will count as yes, the child examines new objects.

Item #41. When mother says to follow her, child does so. Don't count refusals or delays that are playful or part of a game unless they clearly become disobedient. What if the mother calls to the child, "come here", from another room. Is this relevant to the scoring of this item? My first reaction to the item is like, when the mother is moving to a different place and she's with the child, sometimes she tells the child to follow her. And that's what the item is referring to. When she's in a different room, I think that that could be captured in other items, like following mother's suggestions or being obedient. But my first reaction to this item was like, when the mother is leaving the place they're at and she says to the child "come with me", not when she's calling him from another room, but I'm not sure we should disregard this information altogether. But certainly, the main thing is when the mother reaches out and asks him to follow her.

Item#43. Needs clarification on keeping track. If child keeps track but does not stay closer than task of keeping track of mother requires, wouldn't this go in the middle? On Jacob, Posada gives a seven and gives evidence of his keeping track as the rationale. The item says: Child stays closer to mother or returns to her more often than the simple task of keeping track of her requires; low, doesn't keep close track of mother's loca- tion or activities. Regarding the question, I would agree that that situation would go in the middle. Well, probably, I had to push it up and because of that, I thought that it would go up. But I tend to agree with the interpretation they give.

Item#44. Child asks for and enjoys having mother hold, hug or cuddle him. Needs more clarification. Brian says enjoying is more important than asking for. Posada tends to rate this lower because he doesn't see clear evidence of the child's asking. Well, in principle, I agree with what Brian is saying. I think that this item is looking at enjoyment the child has. One way of expressing it is by asking. But yes, I think that it focuses in the child liking the mother holding him or hugging him or cuddling him. That's fine. I'm hope I'm not focusing on asking because that's not really the intent of the item. I mean, asking is just one way of showing interest.

Item#45. Brian indicated that the child should be singing or dancing along with music. Posada places this item high for Jacob, who was singing a little bit on his own. The item says: Child enjoys dancing or singing along with music. Low, neither likes nor dislikes music. Well, it's both. If there is music playing and the child dances and moves his feet and sort of likes it, it's evidence. Now, if the child sings, it counts as evi- dence also. That's the way to look at it.

Item#46. A question about bumps and stumbles. Posada tends to rate lower than Brian. Brian says we should consider the coordination of the two year old and that this item would not likely go very low. Well, you're comparing child behavior to child be- havior. If the child bumps and drops, or stumbles and falls, this counts as high. If he doesn't, it doesn't. I don't know if I really tend to rate it lower than Brian. You should go by what you see in the visit.

Item#48. Posada puts this in the middle if the visitor doesn't

ask to see the toy. Brian says if the child shows a toy, it doesn't matter whether the visitor asked or not. The item says: Child readily lets new adults hold or share things he has, if they ask to. I think, as I said before, in reference to a different item, if the visitors, this is in the context of the child's being asked by the visitor to share things. That's the way I look at that item. As Brian says, if the visitors don't ask, yet the child is sharing with them, most likely I get the assumption that if the visitors asked for anything the child is holding, it's likely that the child would share it with them. It's evidence that the child would do it. So I would count this type of evidence for this item.

Item#51. If child doesn't climb all over visitors but does come close, will it be in the middle? The categories are very confusing. The item says: Child enjoys climbing all over visitors when he plays with them; low, doesn't seek close contact with visitors when he plays with them. Well, I think that the item, very specifically, refers to the child's establishing some kind of physical contact with the visitors. Some children will jump all over you, will lean against you, will just touch your arms, your legs. Others, they play with you, they're very interactive, but you see them keeping a distance. So this is what the item refers to. Some children just don't have any problem establish- ing physical contact with visitors. Some others do. And you get a sense, I guess, for children who sort of have a preference for not very close contact. That's what it's referring to.

Item#55. Posada seems to dismiss or not give much weight to copying verbal responses as evidence of child's copying mother's behavior. Brian definitely counted verbal imitating, which is the most likely behavior we'll see. Yeah, that's probably true. I don't know if I have paid close attention to the verbal behavior. I don't know if I weight it as much. And probably it shouldn't be so. If the child is trying to imitate mother's verbal behavior, it counts as the child's trying to copy mother's behavior from watching her, from listening to her. So, it should count, definitely.

#57) Child is fearless. Low, child is cautious or fearful. The question is: Should we include child's being fearless with the family dog? I wouldn't really give this a lot of weight. But in any case, I think that's just one little piece of evidence that you would have. Hopefully, you would get some more information about other things. But if the family dog has been with the child since he was born, I mean, it's just like, yeah, you count it, but hopefully, you will get more confirming evidence about this item.

Item#59. Posada says the item doesn't count, or would go in the middle, if the child is with the mother all the time. One of our

observers rated Austin high on this because he clearly initiated new activity on his own, without asking mother or seeking her suggestion. Does it have to be only when mom is out of sight? The item says: When child finishes with an activity or toy, he generally finds something else to do without returning to mother between activities; low, when child is finishes with an activity or toy, he returns to mother for play, affection or help finding more to do. Well, the idea of the item is just that the child is somewhat apart from the mother and when he finishes with certain activities, he goes back and sort of establishes contact with the mother, or for purposes of asking her what else to do, whatever. So, if the child is close to the mother, then it's very difficult to give it high placement because he hasn't returned to the mother. The mother is there. So you cannot really place it very high. So I would say to place this item high, clearly and without many doubts, yeah, probably the clearest way of seeing it is when the child is apart from the mother. If he is with the mother, then he doesn't need to go back to the mother for affection, etc.

Item #61. Plays roughly with mother; bumps, scratches or bites her in active play. Doesn't necessarily mean to hurt mom. Does this include hitting because the child is frustrated or angry while playing? No, I think that in the context of play, there are children that are rough with mothers. And they just, this doesn't have to be because the child is angry. There is an item for when the child easily becomes angry with mother. In that case, the hitting will be within the context of being angry. But if it happens, I guess, I mean, in a way it will influence the location of the item a little bit. If it occurs within the context of play. So I guess the answer would be a tempered yes.

Item #61. We just discussed this item. In any case, I think the question is different. It says: Do we assume the child's play is never very active if we don't observe these within the visit, or should we probe the mother further to find out if the child plays actively on other occasions? Well, if you don't see active play in the visit, then you cannot really place this item other than in the middle piles, based on the information that you gather from the mother, if you happen to ask about this item. So you wouldn't be able to place this in any of the extremes, if you don't see active play and the child doing this type of thing.

#62 With a two- to three-hour visit, can we make an accurate prediction about child's mood? What the item is referring to is the child's mood during the visit. So just answer for the session.

Item#64. The item says: Child enjoys climbing all over mother when they play; low, doesn't especially want a lot of close contact when they play. The question is: is this to be judged

only in play? What if the child clearly avoids close contact with the mother and there is little or no play. Posada puts this closer to the middle because of no play. Well, I think that I'm considering this action in the context of play. Because there are different types of situations, I guess. Once situation in which mother/child interactions occur is when they're eating at the table, or in the context of cleaning tasks or cleaning the child. So in any case, yes, I would have put it within the context of play. That's what it means.

#66 How fond does the child have to be to get a rating on #66? Again, this is an item that I think is difficult to see. Yet, you just look for expressions of fondness in the child towards adults and basically towards the observers. So I don't think that we can look for degrees. Just look for expressions of this thing.

Item #76. When given a choice child would rather play with toys or adults. Does watching TV constitute a toy? We already dealt with this. In as much as possible, try to keep TV away from the child.

Item #77. When mother asks child to do something, he readily understands what she wants; may or may not obey. How do we determine that the child understands the child's request? In part, this seems to depend on whether the child does or does not obey. Yes, the way you realize whether the child understands or not is by what he does after the mother tells him to do something. And I think that by that behavior that you could determine whether he does or doesn't understand. He doesn't necessarily have to obey. Sometimes you see disobedient behavior and clearly the child has understood what the mother has told him. But yes, you have to look at what the child does afterwards, after the mother tells him.

Item #78. Child enjoys being hugged or held by people other than his parents and/or grandparents. Why are grandparents included here? Is this question trying to get a child's reactions to hugs beyond immediate family members? If so, many of our children live with aunts, uncles, etc. Should they also be excluded here? Well, the question, I think, refers to whether a child enjoys this type of behavior, being hugged or held by people with whom he's not very familiar. That's all, that's all it means. Generally, these people are not going to be there during the visits. Because the visits are being set up in a way that, for most of them, it's only the mother, the child and the observers and the camera person, if there is a camera person. So, in this case, these other people are going to be the visitors, if the occasion happens to occur for them to be hugged by the visitors. So that's that for that question.

Item#81. Are we concerned with the child's method for getting

what he wants, or are we trying to determine the purpose of the child's crying, whether he's crying for manipulation or out of genuine discomfort? This item says: Child cries as a way of getting mother to do what he wants; low, mainly cries because of genuine discomfort. Well, in a way, what the item refers to is that some children use crying as a way of getting what they want. I think that in one of the tapes, I don't exactly recall which one, but there is, I remember the occasion very clearly. There is a child in the kitchen and he or she wants to reach this kitchen utensil and it's too high. And he/she sort of, the mother is there, and I think that Brian is there, I don't know who else was there, and the child starts like, instead of asking, starts "uh, uh" and starts fussing and sort of crying. Just to get the mother to give him/her the utensil. Genuine discomfort is when the child is distressed or is going through the painful experience, she's fallen down, she's scratched herself or she's done something else to herself. I hope that this answers that. I don't know if we're trying to determine the purpose of the child's crying, but in a way, we are, I think.

#82) How many activities count as just a few? If the child plays mainly with three items, is that "just a few"? This applies to item #82. Even though the item seems very clear, this question comes up frequently. The question gives a "for in- stance" of three items and asks if this is just a few. I don't really know because it depends on what he does with the three items. I mean, some children may play with one or two items throughout the visit, but they use them creatively, they just do various things with the object. So it's not really one activity. But if the child is just focused on one, two, three things throughout the visit, probably, depending on how other descriptives of child's behavior are placed, it's going to wind up being placed with just a few toys or activities. But again, it depends on other behaviors of the child and it depends on how he uses the object. In other words, he doesn't have to play with ten ob- jects, it refers more to activities.

Item #86. Child tries to get mother to imitate him or quickly notices and enjoys it when mom imitates him on her own. Can this imitation be verbal behavior or both? I guess it could be both.

Item #90) If mother moves very far away, child follows along and continues his play in the area she's moved to, doesn't have to be called or carried along, doesn't stop play or get upset. Middle if the child isn't allowed or doesn't have room to be very far away. The low end for this type of item would be when the mother moves far from the child within the house and the child doesn't follow her. The child remains where he or she was playing. And in some occasions, the mother would have to call the child or go and pick him up and move him where she is going in the house. So basically, the low end means the child doesn't really follow on his own. Also I guess if the child winds up being called or picked up and taken to where the mother is, then that means that the child didn't follow the mother, didn't move along with the mother to the place where she was going.

Item#90. The item says: If mother moves very far, child follows along and continues his play in the area she has moved to. Is the issue here whether the child does or doesn't follow, or whether the child ceases play or gets upset by the mother's leaving? The issue is whether the child follows along and continues his play in the area the mother has moved to. The issue is not whether the child gets upset by the mother's leaving. There are other items that cover that aspect. So if the child doesn't follow and continues playing, then it goes to the low end. That's what it means. **What if the child gets upset momentarily and then follows the mother to another room and continues his play?** Most likely, this is what happens. You would rate an item that says child gets upset when mother leaves the room as characteristic, and this particular item, #90, based on whether the child moved or not. And you will also count the upset part with a different item. **What if the child follows the mother but doesn't continue his previous play in the new location?** Well, I guess if a child keeps playing, that's fine. I mean, he continues playing, he didn't continue playing the same thing, but he continued playing in a different place. If he doesn't continue playing and he follows mother, then I don't know, I wouldn't tend to put this item very high, but I wouldn't go to the low end because the child did follow the mother. So it would wind up probably a little toward the characteristic side but not much.

Chapter 23

Section 1

OPERATIONS MANUAL TWENTY-FOUR MONTH LABORATORY VISIT

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Chapter 23

Section 1

OPERATIONS MANUAL 24-MONTH LABORATORY VISIT

I. OVERVIEW OF THIS MANUAL

The laboratory visit at 24 months consists of a series of procedures designed to assess children's cognitive development as reflected by the child's independent exploratory behavior and sustained attention and performance on a standardized cognitive test; to assess the quality of mother-infant interaction and dyadic cooperation/conflict during a toy clean-up session; and to obtain mother-reported information on children's behavior problems and adaptive functioning, as well as on maternal and family functioning. There will be a snack after the Bayley. Section 1 provides general information about the lab visit. Instructions on the Solitary Play procedure and the clean-up procedure are given in Section 2. Instructions for the administration of the Bayley are given in Section 3. Instructions for the snack procedure are given in Section 4. Instructions for the assessment of mother-child interaction are given in Section 5. Procedures for administering standard interview material and questionnaires and instructions for administering two questionnaires about child behavior (ASBI, CBCL) are given in Section 6. Procedures for weighing and measuring the child are detailed in Section 7.

We have attempted to consider as many questions and contingencies as possible. However, situations that we have not anticipated may arise during the course of data collection. When you are presented with a situation that is not covered in the manual, capture it as accurately as possible (e.g., write down the details of the situation), then contact your PI or Bonnie Knoke at the Data Coordinating Center. She will confer with the relevant individuals and give you a coding decision, an interpretational decision, or whatever is needed. These responses will be distributed to all sites by e-mail. Each of these new decisions will then be recorded in an addendum to this manual that will also be distributed to all sites.

II. GENERAL CONSIDERATIONS FOR THE 24-MONTH LAB VISIT

A. Personnel to Conduct the Visit

Two people are necessary to conduct the lab visit. One person, the visit coordinator/examiner, is responsible for greeting the family, explaining each procedure to the mother, and generally coordinating the visit and administering the procedures. The second person serves as operator of the video camera. If necessary, a third person should serve as a babysitter for siblings.

All the members of the laboratory staff should be friendly, relaxed, and professional when interacting with the visiting family. They should be thoroughly familiar with the laboratory protocol. This familiarity will help staff to be comfortable enough to be flexible when problems arise. Staff members should become familiar with 24-month-old children. The staff should wear casual, yet professional clothes. Finally, if the visit coordinator/examiner is contagious with any illness, he/she should find a trained substitute to conduct their portions of the visit.

B. Window for Data Collection

Phone calls to schedule the lab visit (along with the home and child care visits) begin at 23 months. To be within the desired window, the lab visit may occur anytime from 24 to less than 26 months. All visits (but, particularly the lab visit) should ideally occur as close to the child's 24-month birthday as possible. For a given family, the home visit should precede the lab visit. The order of the lab and child care visits can vary. If necessary, visits can be conducted up to but not including 29 months 0 days. All visits conducted on or after 26 months 0 days will be "flagged" as an exception on the data forms and must be approved by a principal investigator. An EXCEPTION PERIOD DATA COLLECTION APPROVAL form should be sent to the DCC along with any data collected on or after 26 months 0 days.

Lab visits for more than one child may be scheduled on a single day, however a 3-1/2 hour block of time should be allotted for each visit. Piloting suggests that families are often late. Diapers need to be changed, etc. Allow sufficient length of time when scheduling families to avoid families having to wait for their visit to begin because another family is being observed.

C. Materials Needed for the Visit

Solitary Play (TOYS PROVIDED BY WASHINGTON SITE)

1. Stop watch
2. Doll with hair that can sit up (and should be left sitting)
3. Miniature baby bottle
4. Miniature hair brush
5. Miniature spoon
6. Miniature bowl
7. Miniature tea pot with lid
8. Sea shell
9. Rectangular wooden block
10. Wooden clothespin (No Springs)
11. Two colored sticks (one yellow, one blue)
12. Plastic "donut" (hole in the middle) which the sticks and the clothespin can fit through
13. Fisher-Price toy telephone (with cord cut, so that receiver can be lifted to ear)
14. Irregularly shaped piece of green washable table cloth
15. Miniature car
16. Four Fisher Price toy people (that can sit in the car as drivers)
17. Two toy animals: horse, cat
18. Two plastic boxes/bins for storing toys during clean-up

Bayley Kit

Snack Materials (See 15 month manual)

Three Boxes
- Red Box (Box 1)
- Blue Box (Box 2)
- Green Box (Box 3)
- Story book: Barnyard Tracks
- Fisher Price Kitchen Set
- Fisher Price Discovery Cottage

Interview and Questionnaires Materials

Height & Weight Measuring Instruments

In addition, each site should have an area set aside for changing diapers. It should include a diaper changing table, disposable diapers, baby wipes, disinfectant for cleaning the diaper changing table, and dishwashing detergent for washing the toys.

D. Observation Rooms

One, two, or three observation rooms each equipped with a 1-way mirror are needed for the 24-month lab visit. The video cameras for these procedures should be hidden behind the one-way mirror. The organization of the room is specified in the sections of this manual detailing the various procedures. Each site is free to choose a 1,2, or 3 room arrangement.

E. Health and Safety Concerns

Listed below are a few health and safety related issues that each site needs to consider as they make their final adjustments on their lab set-ups.

1. Be sure all electrical outlets are covered. In addition to covering the outlets in the experimental rooms, you may want to cover the outlets that are located in hallways which connect the playrooms and any rooms where visiting siblings will be likely to venture.
2. All sites need to make sure that their toy washing facility is independent of the diaper changing area. The Box of baby wipes provided for the mother during snack should not be the same box used for diaper changes. If at all possible, toys and dishes

should be washed in a kitchen where hot soapy water is available for disinfecting the toys. Toys and dishes must be rinsed and then dried after washing.

3. Each site should develop a system/schedule for washing doll clothes on a regular basis.

4. The diaper changing area should include a diaper changing table, disposable diapers, baby wipes, and detergent for cleaning the diaper changing table. Do not use an absorbent pad on the changing table. After washing and rinsing the changing table, it should be wiped dry with a disposable towel.

5. Soiled diapers must be removed from the diaper changing area after each visit. Soiled diapers should be disposed of in a plastic bag that can be removed from the diaper changing area by the visit coordinator after the visit has been completed. Hands should be washed after removing the diaper pail.

6. Each site should have access to a vacuum cleaner for cleaning up the floor around the snack area after each visit. This will be especially important when there are multiple lab visits scheduled on one day.

7. After consultation with faculty in pediatrics and nursing, four bits of advice:

- Don't us Sidex (a very strong disinfectant)
- Wash your hands
- Rinse the toys and tables
- Dry everything after washing with disposable towels.

III. ORGANIZATION OF THE VISIT

A. Confirm with the Mother the Evening Before the Visit

The Visit Coordinator should call the mother the evening before the visit to confirm the visit and make sure the mother is coming. At this time the Visit Coordinator should make certain that the child is not ill.

During the call also remind the mother that we can provide her babysitting money so that she can leave her other children at home. If the mother says that her husband/partner or a friend wishes to come, explain that they will need to observe from the observation room otherwise the child may be distracted by their presence. Finally, remind the mother that we will pay her $30.00 and reimburse her for mileage.

A suggested script to follow is:

"Hi, I'm CALLER NAME from the NICHD Study of Early Child Care. I wanted to call to confirm your visit to our playroom that is scheduled for tomorrow at   (TIME). We have found that the visit to our playroom works best when children are in good health. Is CHILD currently ill? (COLDS ARE GENERALLY UNAVOIDABLE. WE ARE CONCERNED ABOUT FEVERS AND MORE SEVERE SYMPTOMS.)

If the child has a fever or severe symptoms, then reschedule the visit for at least one week later. If the child has a slight cold, go ahead with the visit. If there have been no illnesses, then proceed:

"I look forward to seeing you tomorrow at TIME. You may want to dress your child so that he/she can be weighed in a tee shirt and diaper (or underpants). If CHILD wears heavier clothing, his/her weight will not be accurate. Did you receive the instructions for getting to the playroom? Did you receive your parking permit?" HANDLE ANY OTHER LOGISTICAL ARRANGEMENTS AS NECESSARY.

B. Preparations on the Day of the Visit

The visitor coordinator is responsible for the following preparations:

1. Making sure all toys are clean
2. Cleaning the diaper changing table
3. Arranging the toys for Solitary Play (If more than 1 playroom is used)
4. Making sure a camera person is assigned to the visit
5. Arranging transportation for the mother and child, if necessary
6. Arranging parking for the family, if necessary
7. Make sure materials for 3-boxes procedure, Bayley testing, snack,and maternal interview are available.
8. Zero balance the scale and check to be sure that it has been calibrated within the past week. Also check to be sure that the yardstick to be used to measure the child's height is securely attached to the wall.

The camera person is responsible for arriving sufficiently in advance of the visit to check and prepare the camera and to film the initial family identification at the beginning of the tape. One hour preparation time is recommended in case there is a video malfunction to correct.

C. Family's Arrival

If necessary, the visit coordinator should meet the family in the parking lot, at the door of the building, at the elevator, etc. Care should be taken that the family does not become lost or have difficulty parking. (Free parking should be provided, if necessary). If the mother experiences an unpleasant or difficult trip to the lab, she will be less likely to bring the child to the lab at 36-months.

When the mother and child arrive, the visit coordinator should offer a friendly greeting, asking how everything is going, etc. For example, "Hello, Mrs. SURNAME, I'm VISIT COORDINATOR'S NAME. It's nice to see you again (if previously seen). I appreciate you bringing CHILD in to our playroom today. How has everything been going for you and CHILD?"

Be sure to notice and comment on something positive about the child to the mother. Not saying anything is sometimes taken as a slight. Saying something honestly nice is easy to do about most 24-month-olds. Be careful not to overdo it or to say anything judgmental that could be taken as a negative -- even an innocent comment can stay on the mother's mind for a long time.

The initial greeting should take place in the hallway. After the greeting, the mother's and child's things (stroller, diaper bag, coats, bottles, pacifier, etc.) should be stored in a room other than that in which mother and child will be studied. Tell the mother we are interested in how CHILD behaves without pacifier, bottles, etc. at hand, but let her know that the child can hold on to such things if mother judges that taking them away would seriously disturb the child. Once these materials have been stored, and parent and child have been given the chance to go to the bathroom, go to the Playroom and begin the solitary play procedure (see section 23.2).

D. Sequence of Procedures

Listed below is a brief summary of the sequence of the 24 month lab visit.

1. Welcome and initial instructions for the mother (Conducted in the hallway or office)
2. Solitary play and clean-up (20 mins.)
3. The Bayley (MDI) (30 Minutes)
4. Snack (10 mins.)
5. 3-Boxes Mother-Child interaction assessment (15 mins.)
6. Administration of Standardized Interview, ASBI, CBCL and, if necessary, questionnaires not already completed by mother (52 mins.)
7. Weighing/Measuring Child
8. Wrap-up (Debriefing, Thank you, Payment, Discussion of the Next Visit) (10 Minutes)

E. Expressing Appreciation

Be sure to emphasize at some point during the visit the importance of the family's contribution to the research, how worthwhile and important the research is, and how much the family's time is appreciated. This is often a good thing to do when the mother and child arrive and when they leave.

F. Handling the Presence of the Father or Other Children

Because some mothers may come to the Laboratory with their husband/partner and/or other children, sites should develop procedures to accommodate other family members during the lab visits. Sites should have a room available in which family members may wait. The room should be equipped with toys and something for the father to read. Sites should provide a person to supervise the siblings of the study child if the father is not present. Family members, if they are quiet, may observe the visit from the observation room. Under no circumstances can family members be present in the playrooms during Solitary Play, Bayley administration, 3-Boxes or any other procedures.

G. Taping the Visit

The snack, solitary Play/clean-up, and 3-Boxes procedures will be recorded on videotapes. The taping can be handled in one of several ways: using a single original tape or multiple original tapes. Whichever taping approach is used, copies of procedures will be sent to select locales for coding (see Section IV.C.). After coding, the coding center will send the tapes to the Data Center for archival. Because of the limited length of each segment (est.=20 mins), several segments from different subjects can be taped on a single cassette. The specific instructions for taping each procedure are included in the sections describing the particular procedures. The following general instructions apply to all filming done during the laboratory visit.

1. At the beginning and end of the visit, record (both visually and audibly) the subject's number on each tape, as well as information on the ID number of the visit coordinator and camera operator. Use a board that says "begin subject #920001" and have someone read this message at the same time. After the family has left, follow a similar procedure to indicate the end of the tape, "end subject 920001."

2. Family and staff who are observing any part of the procedures from behind the one way glass must not talk during the visit. It is important not to distract subjects in the playroom and talking can be heard through the observation window. If it is necessary to communicate, soft whispers must suffice.

3. Staff who are filming procedures from behind one way glass and all persons standing near the one-way mirror should wear dark-colored clothing. Otherwise, the reflection of light-colored clothing will be captured by the videocamera and reduce picture quality. Lights in the observation room should be turned off or turned very low during filming because video cameras catch the reflection of the light against the window.

H. Ending the Visit

1. Debriefing

At the end of the visit, the mother should be "debriefed". Ask her if she has any comments or questions about the visit she would like to share with us.

2. Paying the mother

Thank the mother for all her time and help. Reiterate how important the study is, and how we value her time and help. Pay her $30.00, or make arrangements to pay her. If the Solitary Play, Bayley or 3-Boxes Procedure are not completed then the visit should be rescheduled. The mother should be paid when the visit is completed.

3. Reimburse the mother for mileage driven to the laboratory

Reimburse or make arrangements to reimburse the mother for the mileage to and from her home and the laboratory. Use the rate and procedures determined at your site. If possible, prior to the lab visit, determine the mileage to and from the mother's home and the laboratory by using the mileage obtained from the home visit form. If possible, reimburse the mother for transportation costs at the end of the laboratory visit.

4. Preparing for the next contact

Talk with the mother about the next contact. Usually, the home visit will have already been completed. If not, make any necessary final arrangements. For children who are in child care, the child care visit may or may not have already taken place. If it has not, remind the mother of this visit and answer any questions the mother may have. For many families, the next contact will take place at 27-months with the Phone Call update.

Prepare the mother for this call. Say something like, "We will call when CHILD is about 27-months to talk with you about any changes that have happened in your life."

5. Departure

Leave the mother with a good feeling about the visit. As she leaves, give the mother positive feedback along the lines of "You've really been helpful to us." "I've enjoyed meeting you, I'll look forward to seeing you again." "It was a pleasure seeing CHILD."

IV. POST-VISIT ACTIVITIES

A. Checking the Data

After the visit is completed, the camera person should check to make sure that the videotapes of the Solitary Play/Clean-up and 3 Boxes procedures are codable. The Visit Coordinator should check over the Bayley, Interview and Questionnaires, and growth data to make sure all the information is correct and complete.

B. Documentation of the Visit

The Visit Coordinator should enter any pertinent information on the family and the visit in the site's Contact Log Book. She should also complete the Lab Visit Report Form (Appendix A).

C. Copying, Labeling, and Sending the Tape

Copying the Videotape

Original videotapes will be copied in 3 separate segments for mailing to coding centers.

1. Solitary play and snack will be sent to Seattle; up to three separate cases can be copied onto each tape sent to Seattle. On the spine of each tape sent to Seattle for coding indicate the length (in minutes) of the snack sessions.

2. Clean-up procedures will be sent to Dallas. Four cases will be copied onto each tape sent to Dallas. The copied segment should extend from the giving of instructions to mother to the taking of the toys away at the end of the session.

3. The 3-Boxes procedures will be sent to Dallas. Four cases will be copied onto each tape sent to Dallas. The copied segment should extend from the giving of instruction to mother to the taking of the boxes (and toys) away at the end of the session.

Labeling the Tape

The videotapes should be labeled using labels provided by the DCC. The date of the visit and the VC ID number should be written in the space provided on the label. The labels should be placed on the outside spine of the tape and the tape box. Do not include any other identifying information on the box or the tape.

Where to Send the Tapes

The copies of the **Solitary Play and Snack** tape should be sent by regular mail for coding to the following address:

Dr. Susan Spieker
CDMRC, WJ-10
University of Washington
Seattle, WA 98195

The copies of the **Clean-up and 3-Boxes** (on separate tapes) should be sent to:

Dr. Margaret Owen
Timberlawn Psychiatric Research Foundation
P.O. Box 270789
270 Grove Hill Road
Dallas, TX 75227-0789

After coding, these tapes should be sent to:

Bonnie Knoke
Data Coordinating Center
Study of Early Child Care
NICHD/DESPR
9000 Rockville Pike
Bethesda, MD 20092

Where to send the Bayley Score Sheets

The Bayley score sheet should be sent to the Data Center. Be sure to include an appropriately completed multi-purpose cover sheet (form DM-I) with the Bayley score sheet . A copy of the score sheet should be kept at the site.

D. Cleaning Up After the Visit

The Visit Coordinator is responsible for insuring that the toys are cleaned after the visit. The toys should be washed using hot water and dishwashing soap. The diaper changing table should also be cleaned with disinfectant, if it was used. The scale should be cleaned or the paper covering the bottom of the scale should be changed after each child is weighed.

V. ENCOUNTERING UNUSUAL CIRCUMSTANCES

Any number of circumstances can arise which could potentially derail the successful implementation and completion of the laboratory visit. Listed below are several possible problems that might be encountered and recommended solutions. It is impossible to anticipate all potential problems. The visit coordinator should thus maintain an attitude that permits "thinking on his/her feet" in order to successfully confront challenges that might arise. Foremost to keep in mind are (a) the needs of the mother, child, and family, and (b) our desire to obtain high quality data. Solutions that seriously discomfort families and breed resentment which could undermine further participation in the project must be avoided. At the same time, however, the visit coordinator must be prepared to work hard to find a solution that will enable him/her to obtain high quality data consistent with the other sites.

A. Video Malfunction

Videocameras should be tested an hour before the visit. If the equipment is not working and cannot be fixed and another camera is not available, then the family should be called and the visit rescheduled. If the family cannot be contacted before they arrive at the playroom, then the Bayley, interview/questionnaires, and growth procedures should be conducted and the rest of the visit rescheduled, or the whole visit can be rescheduled.

1. Solitary Play Procedure

If there is a camera malfunction during the solitary play procedure, the following rules should be followed.

a. If there are at least 10 minutes of solitary play on tape, then the tape is codable.

b. If the camera operator suspects there is a problem during the procedure, then he/she should continue filming until 10 minutes have been filmed. At this point, s/he should check to see if the child's play is being recorded on the tape. If so, the tape should be fast forwarded to where taping was stopped and taping should continue until the end of the play session. If there is a malfunction, the camera operator should knock on the lab door, stick his/her head in the room, and inform the examiner that a video malfunction has occurred. At this point, the examiner should terminate the solitary play session, forego clean-up, and proceed directly to administration of the Bayley. While the Bayley is being administered, every effort should be made to get the video system to work. If this proves impossible, the examiner should be informed and proceed directly from the Bayley to the administration of the interviews and questionnaires. But if the video equipment is working, the examiner should proceed as if everything had gone smoothly, moving on to the snack, 3-Boxes procedure, and then to the interview/questionnaires. While mother is doing the interview, the solitary play toys should be laid out once more and the child given the opportunity and encouragement to play with them. After the full 15 minutes of play has been recorded (includes any earlier play that was video recorded successfully), the interview should be interrupted so that the clean-up can be administered. Once this is done, the interview should be continued.

2. 3-Boxes Mother-Child Interaction

If the camera operator suspects video malfunction, s/he should stop recording after five minutes and check the equipment. If the procedure is being recorded, s/he should continue recording where s/he left off. If no video record is being made, the camera person should interrupt the 3-Boxes session, inform the examiner of the malfunction, and the session should be terminated. The examiner should then proceed to the interview session. If the equipment can be fixed, the 3-Boxes materials should be initiated again. If the video equipment cannot be fixed, the 3-Boxes assessment data will be treated as missing.

B. Family has Difficulty Coming to the Laboratory

Sites should make every effort to make sure the family is able to come to the laboratory. Transportation can be provided. Staff should be flexible about working whenever the families can come (evenings, weekends, schooldays, whatever).

1. Mother has child care difficulties

If there are siblings who need to be cared for during the visit, the site should offer to pay for babysitting or provide someone at the laboratory to babysit the siblings during the visit.

2. Mother does not have a car

If the mother does not have a car, the site should offer to pay for a taxi to bring the mother and child to the playroom. The site should arrange for free parking and reimbursement for mileage for mothers who have cars.

C. Child Arrives Tired or Ill

If the child is tired or ill, the visit coordinator will need to judge whether the visit should be canceled and rescheduled. The visit should be rescheduled if the visit coordinator believes that the child's behavior will be seriously affected by the child's condition.

D. The Family Does Not Arrive

If the family does not arrive at the scheduled time, the visit coordinator should call the home to determine if the mother forgot or is having difficulty with transportation. If the mother forgot the visit, the visitor should first attempt to have the mother come immediately. Otherwise, the visit should be rescheduled. If the mother is having difficulty with transportation, the visit coordinator should arrange for a taxi and pay for the taxi upon its arrival.

E. Number of Times a Visit Can Be Rescheduled

The visit may be rescheduled as many times as necessary. However, the visit should take place before the child is 29 months of age. If a visit is completed when the child is between 26 months 0 days and less than 29 months of age, then this data must be flagged as late and an Exception Period Data Collection Approval Form (form DM-G) needs to be completed and sent, with data, to the DCC. Visits should not take place on or after the child's 29 month birth date.

F. Child Needs a Diaper Change

If the child has a bowel movement and needs a diaper change in the middle of the procedure, the child's diaper should be changed immediately. Stop the clock. Show the mother where she can change the diaper. (Sites should have a diaper changing area available). Start the clock when mother and child have returned to the play room. The only exceptions to this rule would be if there were only a minute or two to go for a certain procedure.

VI. OVERVIEW OF THE TRAINING FOR THE 24-MONTH LAB VISIT

Training for the 24 month lab visit will occur during October, 1992 in Pittsburgh, PA. This training will occur over two full days. Research assistants should arrive the night before the training.

Responsibility for training personnel to conduct the solitary play procedure is assumed by Sarah Freidman. Jay Belsky will conduct training for the clean-up assessment. A representative for Psychological Corporation will oversee training on the Bayley. Margaret Owen will be in charge of training for the 3-Boxes procedure; Marsha Weinraub will be responsible for interview-questionnaire administration training. Sarah Friedman will be in charge of the training for the growth procedures. Jay Belsky, chair of the 24 month lab visit, will oversee the coordination of the training session (including snack procedure). Details of the training for individual components of the lab visit are detailed in their respective sections.

Appendix A

24 Month Lab Visit Log (25A)
and Monitoring Form (25I)

24-MONTH LAB VISIT LOG

bject Number						
Week						
Date of Lab Visit						
Visit Coordinator						
Interviewer if different from V.C.						
Camera person						
23-mon. info given to secretary						
Reminder letter mailed						
VISIT COORDINATOR						
Phone call night before						
Toys & Changing table washed						
Arrange toys						
Prepare snack						
Solitary Play completed						
Clean-up completed						
yley completed, checked, sent to DCC						
3 Boxes completed						
Quest/Interview completed, sent to DCC						
Height & Weight completed						
Mother paid $30 & mileage						
CAMERA PERSON						
Cameras checked before visit						
Subject Information recorded before visit on tapes						
Solitary Play, Clean-up, 3 Boxes, Snack tapes checked, labeled, mailed						
Solitary Play, Clean-up, 3 Boxes, Snack Copied for site						
Solitary Play segment copied for family tape						

The NICHD Study of Early Child Care
Form 25A Revision 10/20/92

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24-MONTH LABORATORY VISIT - MONITORING FORM

ID NUMBER						RE
0	0	0	0	0	0	0
1	1	1	1	1	1	1
2	2	2	2	2	2	2
3	3	3	3	3	3	3
4	4	4	4	4	4	4
5	5	5	5	5	5	5
6	6	6	6	6	6	6
7	7	7	7	7	7	7
8	8	8	8	8	8	8
9	9	9	9	9	9	9

DATE

Month		Day		Year 199
0	0	0	0	2
1	1	1	1	3
	2	2	2	4
	3	3	3	
	4		4	
	5		5	
	6		6	
	7		7	
	8		8	
	9		9	

INTERVIEWER ID

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

TIME VISIT BEGINS
(use 24-hour clock)

0	0	0	0
1	1	1	1
2	2	2	2
	3	3	3
	4	4	4
	5	5	5
	6		6
	7		7
	8		8
	9		9

INITIAL MOTHER INTERVIEW:

1. Have you and CHILD had any unusual separations during the previous week?	☐ yes ☐ no
2. Has this been a typical day for CHILD?	☐ yes ☐ no
3. (If no): Why not?	☐ child sick (includes teething) ☐ mother sick ☐ child off schedule ☐ child's behavior different in some way ☐ other
4. (If no): How different was it?	☐ only slightly ☐ somewhat different ☐ really different

5. Number of hours since child was picked up at child care?
(Do not ask if child is not in child care.)

0	0
1	1
2	2
	3
	4
	5
	6
	7
	8
	9
NA	

6.	Were you and CHILD together for the two hours before the visit?	☐ yes ☐ no
7.	Has there been any major change in your work situation in the last two weeks?	☐ yes ☐ no

(If yes): What was the change? (Code all that apply.)

a ☐ Stopped employment
b ☐ Reduced hours of employment by 10 or less hours
c ☐ Reduced hours of employment by more than 10 hours
d ☐ Increased hours of employment by 10 or less hours
e ☐ Increased hours of employment by more than 10 hours
f ☐ Began employment (20 or less hours/week)
g ☐ Began employment (21-30 hours/week)
h ☐ Began employment (31-40 hours/week)
i ☐ Began employment (41 or more hours/week)
j ☐ Changed employer
k ☐ Changed place of employment from home to outside of home
l ☐ Changed place of employment from outside of home to home
m ☐ Other______________________________

BASED ON MOTHER REPORT AND COORDINATOR OBSERVATION:

8.	Child rested	☐ yes ☐ no
9.	Child healthy	☐ yes ☐ no

COORDINATOR EVALUATION OF PROCEDURES:

10.	Solitary Play	
	Completed	☐ yes ☐ no ☐ yes, at a prior visit
	Terminated because of child behavior	☐ yes
	Terminated because of mother request	☐ yes
	Terminated because of equipment problems	☐ yes
11.	Clean-up	
	Completed	☐ yes ☐ no ☐ yes, at a prior visit
	Terminated because of child behavior	☐ yes
	Terminated because of mother request	☐ yes
	Terminated because of equipment problems	☐ yes

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12. Bayley

Length of time needed to administer (minutes):

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

Completed ☐ yes ☐ no ☐ yes, at a prior visit

Terminated because child too tired ☐ yes

Terminated because child too active ☐ yes

Terminated because child becomes ill ☐ yes

Terminated because of other child behavior ☐ yes

Terminated because child's first language is not English ☐ yes

Terminated because of mother request ☐ yes

Terminated because of equipment problems ☐ yes

13. 3-Boxes

Completed ☐ yes ☐ no ☐ yes, at a prior visit

Terminated because child too tired ☐ yes

Terminated because child becomes ill ☐ yes

Terminated because of other child behavior ☐ yes

Terminated because of mother request ☐ yes

Terminated because of equipment problems ☐ yes

14. Height and Weight

Completed ☐ yes ☐ no ☐ yes, at a prior visit

Terminated because of child behavior ☐ yes

Terminated because of mother request ☐ yes

Terminated because of equipment problems ☐ yes

15. Standardized Interview

Completed ☐ yes ☐ no

If no, what was the last item completed? ________________

What plans were made for completing the interview?

Scheduled another lab visit	1
Scheduled another home visit	2
Other ________________	3

Did mother request assistance in answering any questions (Defining a word, interpreting a question, etc)? ☐ yes ☐ no

If yes, indicate for which questions and the information given her:

____
____
____
____

Describe any significant extenuating circumstances that may have made this interview unusual.

____
____
____
____

Mother's comments following interview (when you ask her if she has questions or comments)

____
____
____
____

Interviewer's Comments:

____
____
____
____

16. Lab Visit Questionnaires: CBCL and ASBI

Collected

☐ yes
☐ no
☐ yes, at a prior visit

If no, what was not completed: ____________________

What plans were made for completing questionnaire(s)?

Scheduled another visit	1
To be returned by mail	2
Other ____________	3

17. MacArthur Inventory

Completed

☐ yes
☐ no
☐ yes, at a prior visit

If No, what plans were made for completing the questionnaire?

Mother will return by mail	1
Distribute to mom and pick up at home visit	2
Other ____________	3

18. Standardized Questionnaire Packet

Collected or completed at the lab visit

☐ yes
☐ no
☐ yes, at a prior visit

If No, what plans were made for completing the questionnaire?

Mother will return by mail	1
Distribute to mom and pick up at home visit	2
Other ____________	3

19. Physicians Contact Form

Completed

☐ yes
☐ no
☐ no, mother refused

Chapter 23

Section 2

PROCEDURES FOR MEASURING/SCORING INFANT SOLITARY PLAY AND CONDUCTING CLEAN-UP/COMPLIANCE ASSESSMENT

24-MONTH LABORATORY SESSION

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ACKNOWLEDGEMENTS

The solitary play procedure was developed by Jay Belsky and Sarah Friedman taking into account suggestions from Karen Livesey. Susan Spieker and Jean Gowen assisted in the selection of the toys. The coding of levels of play is based upon that developed by Belsky and Most (1981) who conducted a cross-sectional investigation of the development of play by studying children at 1 1/2 month intervals from age 7 1/2 to 21 months. The Belsky and Most (1981; Vondra & Belsky, 1991) system was based upon work carried out by a number of other researchers (e.g., Bates, E., 1979; Fein & Apfel, 1979; Fenson, Kagan, Kearsley & Zelazo, 1976; Fenson & Ramsey, 1980; Nicolich, 1977) and has been used extensively to study the development and exploration of play. The procedures for coding attention from tapes of the solitary play session were written by Sarah L. Friedman. These procedures are adapted from a study by Z. Breznitz and S. L. Friedman (Journal of Child Psychology and Psychiatry, 29, (3), 267-279, 1988).

Chapter 23

Section 2

PROCEDURES FOR OBSERVING/CODING INFANT SOLITARY PLAY AND CONDUCTING TOY CLEAN-UP ASSESSMENT

24-MONTH LABORATORY ASSESSMENT

I. OVERVIEW

The purpose of this procedure is to obtain a sample of children's self-directed exploration/play in order to (a) scale the cognitive sophistication of the child's activity, (b) measure the child's sustained attention to objects, and at the end of this solitary play assessment, (c) evaluate dyadic cooperation/conflict during toy clean-up. Toward this end, each child will be presented with a set of play materials used when the children were 15 months old. This set was specifically chosen to permit a variety of play activities that can be scaled from less to more cognitively sophisticated. Children will be allowed to explore/play with these materials for a total of 15 minutes. Most 24 month old children find the opportunity to explore these unfamiliar objects in a comfortable setting (i.e., mother present) very pleasant and have little difficulty remaining involved with the materials (though see trouble shooting later in this section). At the end of the 15-minute play session, mother will be instructed to have the child clean-up the toys, but she will be free to manage this clean-up as she sees fit.

The Solitary Play procedure is used not only to observe the children's play, but also to inform/remind the mothers what the sequence of events of the entire lab session is going to be.

II. MATERIALS AND ARRANGEMENT

All play materials will be provided by the Washington site to all other sites to insure that a standard set of toys is employed. One of these toys is a doll with "hair" that can sit up (and must be placed in the sitting position, facing the child). Each child will be presented with a doll that is dressed in clothing that matches the child's gender (i.e., dress for girls and pants for boys) and racial background. Since the sample composition in each site is known prior to the purchase of toys, each site will prepare all the dolls it needs in order to comply with the requirement to match dolls with children. If no doll representing the race of the child is commercially available, the child's mother will be consulted prior to entering the playroom and her wish regarding the race of the doll will be respected. The other toy items include a miniature bottle, miniature hair brush, miniature spoon, miniature bowl, miniature tea pot with lid, seashell, rectangular wooden block, one wooden clothespin (old fashioned, no springs), two colored sticks, one plastic "donut" (hole in middle) which sticks and clothes pins can fit through, Fisher-Price toy telephone (with dial and cord cut--so that receiver can be lifted to ear), irregularly shaped piece of washable tablecloth, miniature car or truck (that does not make sounds when pushed) with place for round-peg like people who fit in holes (as drivers), four toy people (that can fit into car or truck as drivers), toy horse, and toy cat. The bottle should be standing up, and the receiver should be placed on the body of the phone.

III. PROCEDURES

After greeting the mother and making her feel at ease (as described in Chapter 23.1, IIIC), and before entering the Solitary Play room (that was set specifically for that procedure) prepare the mother for the Solitary Play procedure and her involvement in it. The mother needs to be informed that she and her child will enter a room with a one way mirror and that she will be shown where to sit. The VC should also instruct the mother to inform the child about the procedures prior to entry into the room which was set with the toys. The child will either sit in her lap or stand next to her until he/she gets interested in the toys that are placed on the floor in a semi-circle. Instruct the mother that when the child is ready she will lead the child to the center of the semi-circle and have him or her seated there. If the child refuses to sit, the mother should be instructed not to force the child to sit. The mother is not to tell or suggest the child how to explore or play, even if the child brings a toy to show her. Should the child come to the mother to share a toy the visit coordinator will instruct the mother how to behave, always reminding her about not making specific suggestions. Specific suggestions to be avoided include naming the toys, telling the child how to use them or asking the child what he or she is going to do with a toy. If the child moves around so that his/her body and face are not facing the mirror, the visit coordinator will instruct the mother to reposition the child.

Following these preliminary instructions, the visit coordinator will check with the mother to see if the child is in need of a diaper change. If necessary, the child will be changed. If not, the visit coordinator will lead the mother and child into Playroom A.

The playroom should have virtually all possible interesting distractions removed. This means that garbage pails and other things on floors should be moved. This also means that interesting drawings be out of reach or behind barriers or that other efforts be made to keep distractions out of view of the child.

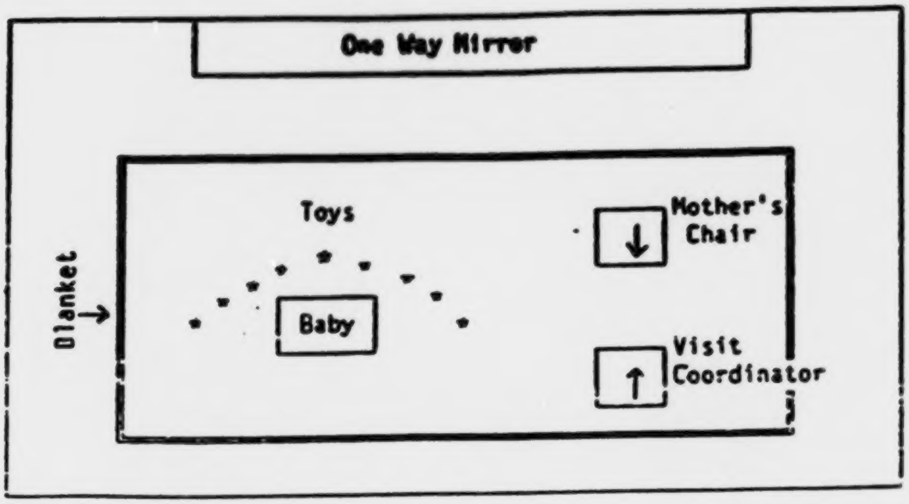
Toys should be arrayed in a semi-circle (not a horse shoe) in such a way that there are spaces of an adult's hand width between objects that are not a part of a natural set. Toys that are part of a natural set, e.g., tea pot, bowl and spoon, should be placed in virtual contact with each other but the child should still be able to see each toy when the child is sitting at the center of the semi-circle of toys. When sitting at the center of the semi-circle the child needs be able to reach all the toys either by extending the hand or by leaning forward to reach the toys at the extreme right or left of the semi-circle.

The mother's chair should be positioned no more than two feet away from the toy closest to it. The chair should be positioned so that the mother faces the visit coordinator and her back is facing the wall behind the video camera. With this arrangement, the mother's face can be seen by the child when the child, who is seated in the center of the semi-circle of toys, lifts his/her head to look in the direction of the mother's chair. The visit coordinator's chair should be positioned so that the child would have to move his/her head or body around, if the child would want to see the coordinator's face. See Figure 1 for room and toy set up instructions.

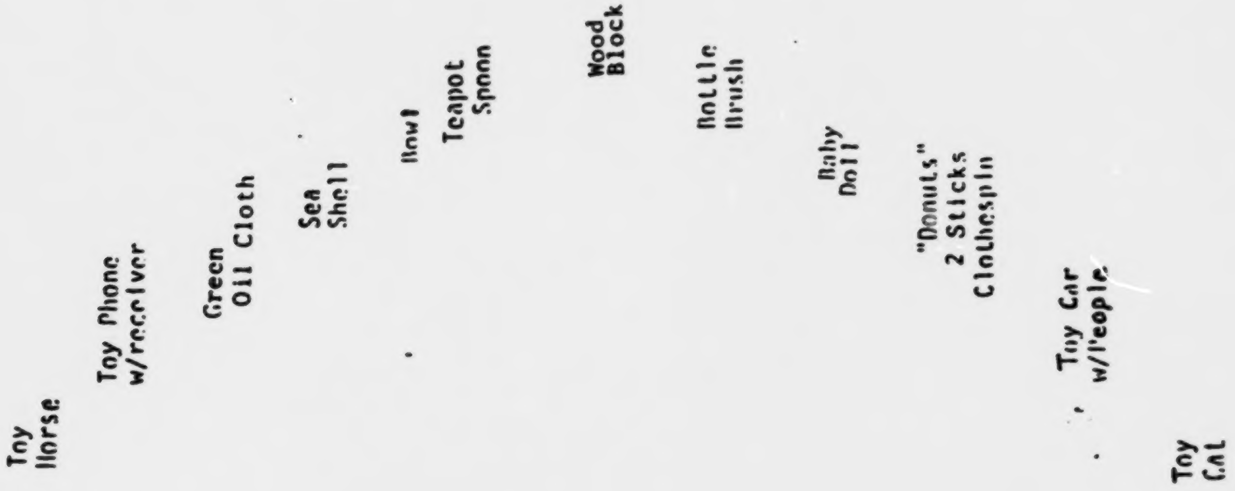
On the way to the room, the visit coordinator informed the mother that she would like the mother to hold her child on her lap until the child indicates that he/she wants to get down and play with the toys that are already arranged on the floor in a standard manner. If the child is not comfortable sitting on the mother's lap, the child may stand next to the mother's chair. When the child wants to get down, or indicates that he/she wants to begin playing (if he/she is standing next to the mother's chair), the mother should take the child and sit him or her down in the center of the semi-circle. Again, the VC should let the mother know that we prefer that the child be seated in the center of the semi-circle, but that she need not force the child to sit.

FIGURE 1

GENERAL LAYOUT FOR SOLITARY PLAY


One Way Mirror
Toys
Mother's Chair
Blanket
Baby
Visit Coordinator

POSITIONING OF TOYS


Toy Horse
Toy Phone w/receiver
Green Oil Cloth
Sea Shell
Bowl
Teapot Spoon
Wood Block
Bottle Brush
Baby Doll
"Donuts" 2 Sticks Clothespin
Toy Car w/People
Toy Cat

It is important to let mother know that her job is simply to talk with the visit coordinator and not interact with the child anymore than is necessary.

Once in Playroom A, if the child is immediately ready to leave his/her mother's lap to play with the toys, let the child do so. Otherwise give the child time to feel comfortable in the room, notice the toys and become curious about them. If after two to three minutes the child has not left the mother's lap, then the visit coordinator should interrupt her comments to mother (see below) and draw the child's attention to the toys by saying his/her name and inviting the child to play, making eye contact with the child and then just tapping with her finger on a few of the toys. This is all the visit coordinator should do with the toys. The visit coordinator should be sure not to manipulate any toy in a manner which reveals how it works. Having engaged in such attention-focussing behavior, the visit coordinator should continue with her comments to the mother. If, after 1-2 additional minutes, the child has not moved off the mother's lap, the visit coordinator should repeat her attention-focussing behavior. If, after another 1-2 minutes, the child has not moved from the mother's lap to the toys, follow directions outlined in the Trouble Shooting section (#2). The play session will be officially started at the time the child started to explore (touch) and object and will be terminated 15 minutes later.

Once the mother sits down on her chair, the visit coordinator should begin to explain to the mother in greater detail than before, what will happen during this activity and the next one. If the child is sitting on the mother's lap while the instructions are being given, the visit coordinator should monitor the child's interest in the toys. If the child shows interest, the visit coordinator may stop the conversation with the mother to verbally encourage the child's interest.

He/she should say something like:

"While CHILD plays for the next 15 minutes, I will explain to you what we will do and what will happen for the rest of your time here today. Before I get started describing the visit's activities I want to tell you again how we would like to handle this play session. Our goal is to enable CHILD to play **ON HIS/HER OWN** with the materials that I have set out, without either of us naming them or suggesting toys for him/her to play with or things to do with them. There will likely be times when he/she looks up to you, shows you a toy, comes over to you or otherwise seeks your attention. What we want you to do is respond to him/her in a way that lets him/her know that you are here and interested in what he/she is doing, without doing anything to encourage his/her focus upon you rather than the toys. I'll try to help you. When I see CHILD wants to show you something I will say something like 'just smile and tell him that it is nice;' If I see him/her come over to you, I will tell you just to lean forward, take what he/she has to offer, and then put it back on the floor beside the other toys. I may ask you to just lean over and give him a pat if it seems like he wants something more; and if he is persistent in his visits to your side, I may even suggest you pick him up for a little bit and then put him back down by the toys. Please feel relaxed and comfortable. What I would like for us to aim for is a situation in which the two of us are talking as CHILD plays at our feet. Before I go on to talk about the rest of the session, do you have any questions at this point?"

Most 24 month old children will remain focussed upon the toys between 10 and 15 minutes. Some will keep busy less than 10 minutes and some will be still focussed at the end of 15 minutes.Strategies for re-focussing them if they do not are detailed below (see Troubleshooting).

Once the mother's questions are answered (if there are any), the visit coordinator should continue with her outline of the full session's events:

"Now let's talk about what else we'll be doing today. You can look behind me at the poster labelled 'Playroom Activities' (see Figure 2) as I tell you briefly what we have planned. Please feel free to interrupt me at any time if there is something you do not understand or are curious about.

Once your child has settled and become comfortable with the toys, we are going to talk in order to create a comfortable setting for your child to play. Then, at the end of the play session, I will leave the room for approximately five minutes during which time I would like to have you get your child to clean-up the toys by putting them back in the plastic boxes I will give to you. Please feel free to handle this clean-up any way you would like, but be sure to involve your child.

"When I return to the room after your child cleans up the toys, I am going to give CHILD some toys and watch what he/she does with them, just as was done during the lab visit at 15 months. Once this is completed, we will take a short break for a snack. After this there will be an opportunity for you and your child to play together with some new toys. Once this is completed, I will want to spend about 30-40 minutes interviewing you as we have done in the past and having you complete some questionnaires. During this time, your child [sites have to outline site specific plans for activities with child at this point.] Just before we finish we are also going to weigh and measure your child."

Now that I have outlined the entire visit, is there anything you want to ask me?

After answering any questions that the mother may have, the visit coordinator should tell the mother that they will be able to chat for the next few minutes (until the play session is over) and that they can discuss anything except the child's child care situation because it is important for the people who code the tapes not to know about the child's child care situation. The following is a list of some topics that might help the visit coordinator keep the conversation with the mother going:

the trip in to the lab (parking, traffic)

extended family

siblings

family pets

the area, where the family lives, the town

2nd Birthday party

vacations

the child' clothing

the child's tv watching habits (favorite shows)

The visit coordinator can also add personal information about himself/herself (no personal problems, though), to keep the conversation going. The visit coordinator can also ask the mother for help in keeping the conversation going. Topics that do not work as well: the words the child knows, toys the child has at home (both of these topics tend lead to naming of objects in the room).

The time on the video recording should be started the moment mother and child enter the playroom. The solitary play session will last for no longer than 21 minutes from this point but the session can be terminated earlier if the child has been in contact with the toys for 15 minutes. Thus the routine solitary play session will be 15 minutes long from the first toy contact or 21 minutes from the time of entry into the room, whichever comes first.

Figure 2

POSTER

PLAYROOM ACTIVITIES

1. Play with Toys
2. Clean-up
3. Structured Activity
4. Snack
5. Mother and child play
6. Interview and Questionnaires
   (plus site specific with child)
7. Weigh/Measure Child

A. Videotaping Solitary Play

In order to code the videotape for sustained attention and levels of play, it is necessary to see on the screen the child's face, body, and hands as well as any objects that are being manipulated. Consequently, the camera person should adjust the zoom lens so that all of these components are captured by the camera simultaneously. The video image should also include the date and time (to the nearest second). The visit coordinator needs to know which parts of the room cannot be captured by the camera and try to get the child away from these blind spots. The camera is to be started when the child, mother, and visit coordinator enter the solitary play room. The goal of the Solitary Play session is to obtain 15 minutes of play from the time the child first explores a toy. The maximum amount of time that the session should run from the time that the mother, child and visit coordinator enter the Solitary Play room is 20 minutes. Since, some children are slow to warm up and take time to get comfortable with the surroundings before playing, it is possible that the session may need to be terminated before the child has played for a full 15 minutes. If the child has not been playing for 15 minutes, the session does not need to be rescheduled. However, if less than 10 minutes of play have been recorded on a tape, the session must be rescheduled.

IV. TROUBLESHOOTING

The most important thing to remember throughout this procedure is that the visit coordinator is free to converse with mother to help facilitate the goal of keeping the child involved in play. Ultimately, our goal is to create a situation that is both familiar and comfortable, resembling something that might happen at the child's home: mother conversing with a friend and child playing at her feet. Despite the best efforts, problems can arise that undermine the procedure. Below is a list of some problems that may arise and ways to deal with them. Figure 3 summarizes the same information. Visit coordinators may want to have Figure 3 handy, so they can refer to it during the session.

1. Child Just Sits and Looks: A child may be apprehensive about engaging with the play materials and may just sit and look at the mother or visit coordinator. If this occurs for 30-60 sec., the visit coordinator should get up from her seat and proceed to tap on several of the toys and invite the child to play. It is most important that the visit coordinator not move or manipulate the object in some way that reveals a unique property (e.g., spin wheels on toy), as this is something we will be measuring and if it occurs we want it to be initiated by the child.

If the child is not enticed by the tapping on the toys and continues to just sit and look for another minute or two, the visit coordinator will invite the mother to sit on the floor either behind the child or with the child in her lap. The visit coordinator will reposition herself so she can continue to talk to the mother without obstructing the view for the camera or making the child uneasy.

2. Child Won't Separate from Mother: Sometimes the child does not want to separate from the mother. It is important not to force the child to separate from the mother, because the whole procedure is predicated upon making the child comfortable. Thus, be alert to mothers who, for whatever reason, are inclined to over encourage their child to get down on the floor and play. If a mother seems intent on encouraging the child to play before the child is ready, the visit coordinator, should let the mother know that there is no hurry, and that it is fine for the child to sit with the mother for as long as the child needs. If, another 1-2 minutes passes after the visit coordinator taps on several toys (first after 2-3 minutes, and then again after another 1-2 minutes), and the child still will not separate, direct the mother to get down on the floor with the child. Tell her she can set the child in front of her or she can have the child sit on her lap. If this happens, the visit coordinator will need to reposition herself so that she can look at the mother, but don't move in a way or to a place that is going to add to the child's uneasiness. It is most important for the visit coordinator, in this and all situations, to maintain a friendly, easy exchange with the mother in hopes of putting the child at ease. In this particular situation, the visit coordinator will need to remind the mother that she is not to play with the child.

2a. Visit Coordinators Misjudges Child's Readiness to Play at Start: If the visit coordinator believes that the child is ready to play and asks the mother to lead the child to the center of the toys, and the child is upset and clearly not ready to play, the mother should be instructed to return to her seat and allow the mother to hold and comfort the child. The visit coordinator will then follow the "Child Won't Separate from Mother" procedure described above, picking up from where she left off before misjudging the child's readiness to play. For example, if the visit coordinator thought that the child was ready to play after she had tapped on the toys one time, the visit coordinator should tap on the again after the child had been sitting on his/her mother's lap for 1-2 minutes more minutes. Then after another 1-2 minutes, the visit coordinator should ask the mother to sit on the floor behind the child.

3. Child Won't Play: On rare occasions a child is sufficiently uncomfortable that he/she will not play, even with the mother sitting on floor nearby. The reason may be that the child is simply too inhibited by the other adult's presence. If this occurs for a minute or two, the visit coordinator should leave the room. Before departing, explain to the mother that children are sometimes uncomfortable in the presence of strangers, so this is the reason he/she is going to leave. BE SURE TO REMIND THE PARENT OF THE ROLE SHE IS TO PLAY--MINIMALLY RESPONSIVE, NONPARTICIPATORY, WITHOUT PROVIDING DIRECTIONS AND SUGGESTIONS FOR PLAY.

4. Child's back to the camera: The visit coordinator will continuously monitor the child's position and evaluate its relationship to the camera. If the child sits with her or his back to the camera for 30 seconds, the mother will be instructed to gently reposition the child with the toy(s) the child is engaged with, thus allowing the child to continue playing with the same object(s). In the case of a child who is mobile and constantly moving around there is no point in repositioning the child. If the child is sitting with his\her back to the camera, but is not engaged with an object, wait for a minute or two, and then tap on the toys, call the child's name, and invite him/her to play with the toys.

5. Child Goes Over to Mother: Sometimes children will interrupt their play to go to see mother. It is our goal to have the child be engaged with toys for as long as possible and thus not encourage mother-child interaction. To achieve this goal, however, the visit coordinator needs to be sensitive and responsive to the child's needs and desires. Thus, when a child gets up to approach the mother, try to anticipate this and remind mother what to do.

5a. Child approaches with a toy: If the child approaches the mother with a toy, remind the mother to accept the toys, say something general such as, "That's nice," and put the toy down on the floor near the other toys (but not necessarily in the semicircle -- the mother need not get up out of her chair to put the toy back). The visit coordinator can also tell the child something like: "I need to talk to your Mommy right now, but she'll be able to play with you later today."

5b. Child asks mother for assistance with a toy: If the child approaches the mother with a toy, and asks the mother to do something instrumental that the child is unable to do for himself/herself (i.e., fix snaps on the doll's clothes, take to spoon out of the tea pot), the mother may help the child. The mother should be instructed to do only what the child is asking and do nothing else with the toy. The mother should not be allowed to do anything that involves interaction between the mother and child.

5c. Child asks the name of a toy: Children this age are likely to ask their mother or the visit coordinator the names of the toys. If the child asks the name of a toy, he or she should be told that it is "Something for you to play with."

5d. Child repeatedly approaches mother with a toy: If the child approaches the mother with a toy 3-5 times in quick succession, the mother should be asked to sit on the floor with the child.

5e. Child Seeking Attention From Mother: If the child appears to need more attention from the mother tell her just to lean over and hug the child if this seems to be all the child wants. If more seems to be needed tell the mother to pick the child up and hold him on her lap for a few moments. When you judge the child to be at ease tell the mother that she can put the child back down in the center of the semi-circle. Usually

30-45 seconds is more than enough. If the child is still upset, the mother should be asked to return to her seat and hold the child from another 30-45 seconds. The above procedure can be repeated 3 to 5 times. The number of times depends on the child's behavior. For example, if the intervals between visits to the mother are very short and/or if the child seems very needy of the mother's attention, repeat the above procedure of the mother hugging or holding the child in her lap 3 times. Following these repetitions, the mother will be asked to sit on the floor behind the child.

5f. Child stands near mother for extended period: If the child stands next to the mother for a minute or two without offering toy or indicating that he/she wants attention, the visit coordinator should suggest that the mother hug or pat the child.

6. Mother Telling/Showing Child What To Do: Despite initial directions to the mother about not showing or suggesting behaviors to children, some mothers will do otherwise (mostly inadvertently). The visit coordinator will need to carefully monitor the mother's input and courteously interrupt her if she starts to give specific play directives. The best way to do this is to simply say "remember we want you to just direct the child towards the toys in general and not offer any specific instructions."

7. Child Wanders Away, But Not Toward Mother: Some children, when they lose interest in the toys, will leave the toy play area or come over to the mirror or to the visit coordinator

for more than a minute or two. In such instances the visit coordinator should go over to the toys, call the child's name, and then tap on several of the toys in an effort to draw the child's attention back to the play objects. If the child does not come back to the materials on his own, the mother would be immediately instructed to pick up the child and bring him back to the toys, again placing him/her in a seated position facing the playthings.

If the child wanders away to an electric socket and starts playing with it, the visit coordinator will not wait any length of time before tapping on the toys, calling the child, and inviting him/her to play. Likewise, if the child wanders toward the door, and the visit coordinator believes that the child can open the door and leave the room, she should tap on the toys immediately without waiting for any time to pass.

8. Child Wanders Out of Camera View: If the child moves into a part of the room that is out of the camera's view and the child is engaged with an object, wait for thirty (30) seconds and then have the mother reposition the child and the toy he/she is playing with in the center of the room. However, if the child wanders into a dead area, but is only standing or moving aimlessly, wait for a minute or two, then tap on the toys, call the child's name and invite him/her to play.

9. Child Repeatedly Wanders Away: Some children will lose interest in the toys repeatedly. If the child approaches the mother or wanders away more than 5 times and cannot be refocussed

except for fleeting periods of time, the solitary play session should be terminated.

10. Interruptions: Unanticipated interruptions can occur, for example, if the baby needs a diaper change (try to do these before child gets started playing, if possible) or starts to cry for some reason. In such cases simply make the necessary adjustments (e.g., change diaper, comfort child) and then pick up the play session once the child is ready to go again. Seek to obtain a full 15 minutes of play, despite the interruption (e.g., 12 minutes before, 3 minutes after). Only if the child wanders repeatedly and cannot be refocussed should a session be terminated before a full 15 minutes.

11. Security Objects: Some children will come to the play session with some kind of security object (e.g., blanket, doll). Ideally we would like the child to leave such objects with the stroller/diaper bag in the storage office and not have them down on the floor with the child, but not at the cost of the child being so uncomfortable that he/she will not play. Thus, ask the mother to take the object in question away from the child, but let her know that if the child will seriously protest, we will not insist on it. Be ready to direct the mother not to bother if it seems as if she may be too assertive in taking something away from the child and that this will upset the child. Pacifiers are acceptable in the playroom, if necessary. Bottles are not permitted unless absolutely required by the child.

12. Using Clinical Judgement: While the manual attempts to provide the procedures for problems that may come up during a solitary play session, it is impossible to foresee every possible event that may occur. Therefore, the visit coordinators should use their best clinical judgements in handling any problems that they are faced with during a solitary play session.

24 MONTH SOLITARY PLAY FLOW CHART

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CHILD WON'T SEPARATE      WON'T PLAY-             SITS ON FLOOR
   STILL ON LAP          MOM ON FLOOR               AND LOOKS
         |           1-2 min |                 30-60 sec |
2-3 min  |                   v                           v
         |               VC LEAVES                      TAP
         v                                      1-2 min  |
        TAP                                              |
1-2 min  |                                               v
         |                                         ASK MOM TO
         v                                     SIT ON THE FLOOR
        TAP
1-2 min  |
         |
         v
    ASK MOM TO
  SIT ON THE FLOOR


CHILD'S BACK             CHILD'S BACK             WANDERS AIMLESSLY
 TO CAMERA                 TO CAMERA                  REPEATEDLY
OR WANDERS OUT          OR WANDERS OUT            (NOT TOWARD MOM)
OF VIEW WHILE            OF VIEW WHILE             1-2 min |
   PLAYING                NOT PLAYING                      |
30 sec |               1-2 min |                           v
       v                       |                          TAP
   ASK MOM TO                  v                   ASK MOM TO MOVE
MOVE CHILD WITH               TAP                 CHILD IMMEDIATELY
      TOY                                           (IF >5 TIME:
                                                    STOP SESSION)


     CHILD APPROACHES MOM:               CHILD APPROACHES MOM:
           WITH TOY                          FOR ATTENTION
immediately: ACCEPT TOY &           immediately: HUG/HOLD ON LAP
          ACKNOWLEDGE CHILD,          30-45 sec          |
   PLACE TOY ON FLOOR AND TELL                           v
   CHILD MOTHER WILL PLAY LATER
(if short intervals between              ASK MOM TO PLACE CHILD
 approaches to mother)                    IN CENTER OF TOYS
                    \                         /
                     \                       /
                      \                     /
                       \                   /
                        v                 v
                   REPEAT 3-5 TIMES IF NECESSARY
               THEN ASK MOTHER TO SIT ON THE FLOOR
```

V. PROCEDURES FOR CLEAN-UP

Once 15 minutes of solitary play has been recorded, or the child has lost interest in the toys and cannot be refocussed, it is time for the clean-up. The purpose of this assessment is to determine how mother and child manage the cleaning up of the solitary-play toys.

Once it has been determined that solitary play is over, the examiner should say to the mother: "I am going to step out of the room now to get the equipment I need for the next phase of this lab visit. While I am gone, I would like you to get your child to clean up the toys. Please have him put them in these boxes (VC hands _directly_ to the mother -- into her hands -- the plastic bins). "_Please feel free to manage the clean-up as you feel most comfortable, but we would like to see your child involved in putting the toys away. I will be back in about 5 minutes._" Ultimately, we don't want to tell the mothers directly that they can help, but we want them to know, that the clean-up is not something the child has to do all by him/herself. We do want mothers to know, though that the child should participate and thereby reduce the likelihood that mother will do _all_ the clean-up herself.

The examiner should observe the clean-up through the one-way mirror so that s/he can return to the lab room if all the toys are put away before 5 minutes are up. If, after 5 minutes, the toys are not all put away, s/he should return to the room to set up the Bayley testing and finish the solitary play clean-up herself. At this point, the VC should not solicit assistance from the child; just clean up the remaining toys as efficiently as possible. In sum, it is critical that (a) the VC only direct the mother to get the child involved in the clean up and to manage the clean up as she deems appropriate and must avoid any suggestion that she should help or assist the child or that the two of them should clean up together; (b) the bins should be placed into the mothers' hands not set on the floor or handed to the child; and (c) that VC return right after all the toys are in the bins or 5 minutes have elapsed (from the time the VC left the room). If the mother asks for any clarification, simply tell her that she can manage the situation any way that makes her comfortable -- SAY NO MORE.

If upon return to the room, the child is holding a toy, draw his/her attention to the next set of materials to be used as a tactic for taking the object away from the child. If the taking of the object is resisted by the child, do not prolong a struggle; take it, put it away and move on. The biggest mistake that can be made is belaboring the process of cleaning up objects: Get the task done and move on.

VI. TRAINING TO CONDUCT THE SOLITARY PLAY AND CLEAN-UP SESSION AND CERTIFICATION

Formal training on how to conduct the solitary play and clean-up compliance procedure is to be provided as part of the overall three day training for the 24-month lab visit to be conducted in Pittsburgh, PA. in Oct., 1992. Prior to the formal training, RAs should study this manual. They should then videotape at least one pilot session by September 1, 1992: Send to Sarah Friedman a copy of the solitary play segment and to Jay Belsky a copy of the clean-up segment; and a second tape is to be sent prior to the training. One of the sessions should be 10 minutes and the other session should be 15 minutes. These tapes will form a basis for discussions at the training meeting as to how a range of situations should be handled.

Major goals of the training are for RAs to be able (a) to create a comfortable atmosphere so that the child can play while his/her mother is engaged with the visit coordinator and (b) to know how to respond to situations that arise when the child is not playing with toys. The best way to insure that RAs attain these goals is for each of them to be videotaped with two to three children after the training to insure that they are "good at thinking on their feet". After training Jay Belsky and Sarah Friedman will coordinate this review.

Certification of Solitary Play: Certification of visit coordinators on the solitary play session will be based on the visit coordinators' performance on several taped sessions. The visit coordinator's performance will be based on the criteria that follow. An error on any component or sub-component listed will be counted as one transgression. The visit coordinator will need to provide two tapes, each with less that three transgressions in order to be certified. If the visit coordinator is called upon to use his/her clinical judgement in the tapes to be used for certification, please enclose a note with the tape, explaining the rationale for any actions that do not conform to the procedures described above. If the "certifiers" (Sarah Friedman and Karen Livesey) agree that this action was appropriate, this will not count as a transgression.

1. Room set up: including position of the chairs and toys
2. Initial procedures: Instructing the mother to lead the child to the center of the semi-circle and to attempt to seat the child.
3. Instructions to the mother: (a) including specific instructions about not naming the toys, (b) not suggesting toys for the child to play with the toys, (c) not showing the child what to do with the toys, and (d) about what the mother should do when the child approaches her. (e) The instructions should be given at the start of the session.
4. Trouble-shooting:
   - (a) Child won't separate: (1) tap toys after 2-3 minutes
     (2) tap toys after another 1-2 minutes
     (3) have mother sit after 1-2 minutes
     (4) leave the room after 1-2 minutes
   - (b) Child won't play: (1) tap toys after 30-60 seconds
     (2) have mom sit after 1-2 minutes
     (3) leave room after 1-2 minutes
   - (c) Child's back to camera:

(1) while playing: ask mother to move after 30 seconds

(2) not playing: tap toys after 1-2 minutes

(d) Child wanders around the room or out of view:

(1) while playing: ask mother to move after 30 seconds

(2) not playing: (a) tap toys after 1-2 minutes

(b) then ask mom to move child

VII. CODING METHODS: SUSTAINED ATTENTION

The coder of attention during solitary play needs to have access to a video-tape recorder, a monitor, a video-tape with a record of the solitary play of one of the children participating in the study and a coding sheet. Coding for sustained attention will occur at the University of Washington under the direction of Susan Spieker.

The coding sheet allows for the coding of the following pieces of information:

-The coder's name or i.d.

-The child's i.d.

-The date at which the data was collected

-The site of data collection

-The date of coding

-The clock time at which the solitary play session started. (Clock time is shown on the screen.)

-The clock time at which play with a given object was initiated.

-The i.d. number of the object played with. When a few objects are engaged with simultaneously, all i.d. numbers are noted and the i.d. of the primary object (to be defined later) is indicated.

-The clock time at which play with a given object was terminated.

-Comments. A report on interruptions, reasons for disengagement, refocusing by the visit coordinator or the mother.

Coding of the play session commences when the child is seated in front of the toys and the two adults (mother, visit coordinator) are in their chairs.

LIST OF TOYS WITH THEIR ID NUMBERS:

1	Doll with hair	11	Blue stick
2	Miniature baby bottle	12	Plastic donut
3	Miniature hair brush	13	Toy telephone and receiver (both coded as #13)
4	Miniature spoon		
5	Miniature bowl	14	Green oil cloth
6	Miniature pot with lid (both coded as #6)	15	Miniature car
		16	Four people to fit in car (all coded as #16)
7	Sea shell		
8	Rectangular wooden block	17	Miniature cat
9	Wooden clothespin	18	Miniature horse
10	Yellow stick	19	Other

A. Initiation and Termination of Attention to Objects

Attention is defined in terms of intent (or engaged) visual, tactile or visual and tactile exploration of objects. When the child attends to (e.g. picks up) the first object, the coder notes the time and the object i.d. number. When attention is shifted away from the object for 3-6 seconds, the coder notes the termination of attention. If attention to an object is resumed after a break of 3-6 seconds, a new initiation is noted.

While a shift of attention lasting 3 seconds qualifies as cut-off for coding disengagement, the observer may delay the decision about termination of engagement beyond 3 seconds. Frequently, the disengagement of attention is clear-cut. At times, however, the coder may wish to have more time (up to six seconds) before making a judgment regarding disengagement or shift in attention.

When the child does not put away the first toy (or object), yet picks up another toy and focuses attention on the "new" toy (or object) for a minimum of 3-6 seconds, the coder writes down the same clock time for termination of attention to the first object and the initiation of attention to the second object. Fleeting changes of attention lasting less than a maximum of 6 seconds (3 seconds of the shift plus up to three seconds for recording flexibility) are not recorded.

When the child combines play with more than one object (simultaneous play), the coder needs to decide if the object that was played with first is the more central or the primary focus of attention. No change in the focus of attention is coded for as long as the first object is the primary focus of attention. For example, suppose the child plays with the doll (with hair) and then picks up the miniature brush and brushes the doll's hair. The coder will assume that the engagement with the doll is central to the child's activity and no shift in attention will be coded. Another example: The child plays with the car and then picks up the little people to place in the car. No change in the focus of attention will be coded. The coder will indicate that multiple objects are engaged with, by adding the identifying numbers of the toys that were brought into the central activity (or focus of attention). It is possible to include an object as secondary when the child attends to it but does not touch it. For example, when the child holds out a bottle to the doll, yet does not touch the doll.

It is possible that an object that was ancillary will become central to the child's play with objects. For example, the child may stop brushing the doll's hair and start brushing her own, using the same miniature brush. Such a change, if not fleeting (exceeding a minimum of 3-6 seconds) will be coded. That is, the coder will note the termination time for the child's play with the doll and the initiation time for the brushing of the child's own hair. At times, the child's attention will focus on an aspect of the environment that is not a toy (or toys). For example, the child could look intently in the direction of the mother or the child could manipulate a body part in a way that expresses interest/exploration. This will be coded as attention to "other" (#19). Please note that bids to the mother are not coded as "other", since the child is not attending to or exploring the mother. Even though it may seem to the reader of this manual that making judgments about the central play activity is a difficult task, coders report that it is quite easy.

The child may stop engagement with a given object without moving on to another object. He or she may just sit and look around with an unoccupied expression. When this is the case, the coder codes the duration of this unoccupied episode.

When the child's disengagement with objects is associated with crying, or crawling away from the play area, the coder will note the information in the comments column next to information about the termination of attention. If the cause of crying or crawling away is clear (e.g., the child needs a diaper-change; the child asks for food or drink), the coder will note the apparent cause of disengagement in the comments column.

When the mother interrupts the play, or makes suggestions to the child, this needs to be noted. The coder will make notes such as "The mother told the child to try playing with the car and the people" or "Mother came over and showed the child how to play with the colored sticks."

When the visit coordinator re-orients an unoccupied child, or brings the child back to sit in front of the toys, the coder will note the information.

When the coder cannot see the child on the screen, this is noted as a technical interruption and its duration is measured. In the NICHD Study of Early Child Care the coding of attention will be entered directly into the computer. A special computer program was developed by the staff at the University of Washington.

VIII. TRAINING AND RELIABILITY OF THE CODERS OF SUSTAINED ATTENTION

Training of the coders will be conducted by Sarah L. Friedman and responsibility for the quality of the data will be shared by Sarah Friedman and Susan Spieker. Prior to training, Sarah Friedman provided the coders with scientific articles about attention and during the training, at the University of Washington site, questions about the construct and the coding system were discussed. Following that, Sarah Friedman, Susan Spieker and the coders will code solitary play tapes, using the computer program for entering the data directly into the computer. Issues will be discussed and resolved. 12 tapes for training the coders will be chosen. They will represent children who vary in gender, site and involvement with the toys.

The set of 12 tapes will be selected by Sarah Friedman and Susan Spieker. These tapes will be selected from the pilot tapes that were sent to Sarah for the purpose of certifying visit coordinators to run the solitary play procedure. The full session of each of the 12 children shown in the tapes will be coded. The selected tapes will be of 6 boys and 6 girls from the different sites (at least one per site). The coders will code these tapes independently. Susan Spieker and Sarah Friedman will then go over the coding decisions of the coders and check them for accuracy. Disagreements will be discussed with the coders and consensus will be reached. If necessary, another set of pilot tapes will be prepared, coded and checked in the same manner.

The process will be repeated if Sarah Friedman and Susan Spieker feel that the coders need more practice and guidance.

The coders will be certified when they reach reliability at the .80 level. Reliability will be calculated on the following variables:

1. Latency from "mother sits" in chair to child's first touch of an object.
2. Latency from "child sits" in the middle of the semi-circle of toys to the first touch of an object.
3. Length of available time from first toy touch to end, if the session is less than 10 minutes.
4. Reason for the session being terminated before 10 minutes.
    a. Technical
    b. Child lost interest
5. Total time engaged, reported in minutes and seconds.
6. Number of different toys contacted.
7. Average length of first contact across toys.
8. Total time spent attending to one object only.
9. Total time spent attending to two objects simultaneously.
10. Total time spent attending to three objects simultaneously.
11. Number of unoccupied bouts.
12. Total time spent unoccupied.

Inter-coder reliability will be calculated on every tenth tape coded. There will be periodic checks of the quality of coding by Susan and Sarah. Based on the Breznitz and Friedman (1988) paper, it is expected that reliability between the coders, as calculated by intraclass correlations should not be below .85.

Coding of attention and of solitary play will be independent. No coder will code both attention and level of play of the same children.

The computer program for coding reliability was designed by Timothy Meyers of the University of Washington.

IX. CODING METHODS: LEVELS OF PLAY

A 14-step system will be used for coding the cognitive sophistication of toddler exploration and play. The defining features of each level of play is detailed in Table 1. This system is based upon that developed by Belsky & Most (1981) who conducted a cross-sectional investigation of the development of play by studying children at 1 1/2 month intervals from age 7 1/2 to 21 months. This 14-level scoring system can be reduced further to 5- and 3-level systems by collapsing several levels of play into higher-order play tiers (see Table 2). The 3-level scoring system is based upon findings of Belsky & Most (1981) indicating that the three levels evinced quite different developmental trends.

Table 1

14-LEVEL OF PLAY CODING SYSTEM

1. **Mouthing**--indiscriminate mouthing of materials (e.g., peg, seashell)

2. **Simple manipulation**--visually guided manipulation (excluding indiscriminate banging and shaking) at least 5 sec in duration that cannot be coded in any other category (e.g., turn over an object, touch and look at an object)

3. **Functional**--visually guided manipulation that is particularly appropriate for a certain object and involves the intentional extraction of some unique piece of information (e.g., turn dial on toy phone, squeeze piece of foam rubber, flip antenna of Buzzy Bee toy, spin wheels on cart, roll cart on wheels)

4. **Relational**--bringing together and integrating two or more materials in an inappropriate manner, that is, a manner not initially intended by the manufacturer (e.g., set cradle on phone, touch spoon to stick)

5. **Functional-relational**--bringing together and integrating two objects in an appropriate manner, that is, in a manner intended by the manufacturer (e.g., set cup on saucer, place peg in hole of pegboard, mount spool on shaft of cart)

6. **Enactive naming**--approximate pretense activity but without confirming evidence of actual pretense behavior (e.g., touch cup to lip without making drinking sounds, tilting head back, or tipping cup; raise phone receiver in proximity of ear without making talking sounds; touch brush to doll's hair without making combing motions)

7. **Pretend self**--pretense behavior directed toward self in which pretense is apparent (e.g., raise cup to lip; tip cup, make drinking sounds, or tilt head; stroke own hair with miniature brush; raise phone receiver to ear and vocalize)

8. **Pretend other**--pretense behavior directed away from child toward other (e.g., feed doll with spoon, bottle, or cup; brush doll's hair; push car on floor and make car noise)

9. **Substitution self**--using a "meaningless" object in a creative or imaginative manner in activities directed toward self (e.g., drink from seashell) or using an object in a pretense act in a way that differs from how it was

previously used by the child (e.g., use hairbrush to brush teeth after already using it as a hairbrush on self or other)

10. **Substitution other**--same as level 9, but action is directed toward agent other than self, typically doll or mother.

11. **Sequence no story**--repetition of a single pretense act with minor variation (e.g., drink from bottle, give doll drink; pour into cup, pour into plate).

12. **Sequence story**--linking together of two different pretense acts in "logical" sequence (e.g., take drink, wipe mouth; pour into cup from teapot, then stir with spoon; feed doll with bottle, then "burp" doll)

13. **Sequence pretend substitution**--same as sequence pretend except using an object substitution within sequence (e.g., put doll in cradle, cover with green felt piece as "blanket"; feed self with spoon, then with stick)

14. **Double substitution**--pretense play in which two materials are transformed, within a single act, into something they are not in reality (e.g., treat peg as doll and a piece of green felt as a blanket, and cover peg with felt an say "night-night"; treat stick as person and seashell as cup, and give stick a drink)

Table 2

LEVELS OF PLAY SCORING SYSTEM

SYSTEMS:

3-Level	5-Level	14-Level
Undifferentiated Exploration	Undifferentiated Exploration	1. Mouthing
		2. Simple Manipulation
Transitional Play	Functional	3. Functional
	Transitional Play	4. Relational
		5. Functional-Relational
		6. Enactive Names
Symbolic Play	Simple Pretend	7. Pretend Self
		8. Pretend (doll, cat, horse, parent, visit coordinator.)
	Elaborated Pretend	9. Substitution Self
		10. Substitution Other
		11. Sequence No Story
		12. Sequence Story
		13. Sequence Substitution
		14. Double Substitution

The coding of solitary play will be done by Susan Spieker and staff at the University of Washington. The coder watches the videotape of the child's play and, after every 15-seconds of observation, makes several quick judgements. The coder records the highest level of play that the child engaged in.

With regard to scoring play, it is important to recognize that children can be motorically limited in their ability to manipulate objects skillfully. What is being coded is evidence that the child knows how things can go together and provides behavioral indication of such. For example, a child trying to put the lid on the teapot should be credited with a functional relational act even if he does not completely succeed in getting the lid on the pot. The coder has be to confident, though, that the child was not simply juxtaposing one entity to another (thus code "relational") but recognized and was pursuing a particular relation between lid and pot.

Often times a child needs to provide "collateral evidence" that his/her behavior is as cognitively sophisticated as it might be judged to be. For example, the placement of a spoon into a teapot is not coded as "pretend other" unless there is clear movement of the spoon in the teapot to convey stirring or unless the spoon or pot is then brought to the mouth (in which case a sequence pretend would be recorded). Similarly, rolling a car across the floor is coded simply as "functional" unless accompanied by motor noises which indicate that the child knows the toy is a car. Similarly, for use of the telephone to be coded as pretense, the child must make sounds of some sort with the receiver (as if talking) or dial before raising the receiver to his/her head, or hang up soon after juxtaposing the receiver to his/her head. Sometimes toddlers will simply raise the receiver someplace above their shoulder. This is scored as "enactive naming" unless accompanied by babbling sounds; in such cases, even if far from the head, this is coded as pretense.

X. TRAINING AND RELIABILITY FOR THE CODING LEVELS OF PLAY

Training for levels of play will proceed through a series of training steps.

A. Familiarity

Coder trainees will read scholarly material on the development and coding of play (including scoring manual provided by Jay Belsky) before watching the pre-coded tapes. Questions regarding these codings will be compiled, as will play segments that are confusing, and these will be reviewed when Jay Belsky visits Seattle to conduct formal training.

B. Formal Training

During the 1-1/2 day visit to Seattle, Jay Belsky will formally train coders. First he will review confusions raised by the "familiarity" tapes. Then he will review and code with the trainees new tapes that have not been seen before.

C. Reliability Testing

Before initiating formal coding, each coder-to-be will code 5 tapes. One month after passing this test (and coding real data), coders will take a second reliability test on 5 tapes every 3 months. Thereafter a repeat test on 3 new tapes will be conducted.

XI. Appendix

A. Levels of Play Coding Sheets

LEVELS OF PLAY

CHILD ID NUMBER

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

DATE DATA COLLECTED

Month		Day		Year 199__
0	0	0	0	0
1	1	1	1	1
	2	2	2	2
	3	3	3	3
	4		4	4
	5		5	5
	6		6	6
	7		7	7
	8		8	8
	9		9	9

DATE OF CODING

Month		Day		Year 199__
0	0	0	0	0
1	1	1	1	1
	2	2	2	2
	3	3	3	3
	4		4	4
	5		5	5
	6		6	6
	7		7	7
	8		8	8
	9		9	9

CODER'S ID

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

MARK WHICH MONTH

15
24

QUALITY OF PLAY	1	2	3	4	5	6	7	8	9	10
Uncodeable: Blocked Vision............	1	2	3	4	5	6	7	8	9	10
Unfocussed..	1	2	3	4	5	6	7	8	9	10
Simple Manipulation.........................	1	2	3	4	5	6	7	8	9	10
Functional	1	2	3	4	5	6	7	8	9	10
Relational	1	2	3	4	5	6	7	8	9	10
Functional Relational.......................	1	2	3	4	5	6	7	8	9	10
Enactive Naming................................	1	2	3	4	5	6	7	8	9	10
Pretend Self..	1	2	3	4	5	6	7	8	9	10
Pretend Other....................................	1	2	3	4	5	6	7	8	9	10
Substitution Self................................	1	2	3	4	5	6	7	8	9	10
Substitution Other.............................	1	2	3	4	5	6	7	8	9	10
Sequence No Story.............................	1	2	3	4	5	6	7	8	9	10
Sequence Story...................................	1	2	3	4	5	6	7	8	9	10
Sequence Subst. No Story..................	1	2	3	4	5	6	7	8	9	10
Sequence Subst. Story........................	1	2	3	4	5	6	7	8	9	10
Double Substitution...........................	1	2	3	4	5	6	7	8	9	10
TAPING TERMINATED..................	1	2	3	4	5	6	7	8	9	10

QUALITY OF PLAY	11	12	13	14	15	16	17	18	19	20
Uncodeable: Blocked Vision............	11	12	13	14	15	16	17	18	19	20
Unfocussed..	11	12	13	14	15	16	17	18	19	20
Simple Manipulation.........................	11	12	13	14	15	16	17	18	19	20
Functional	11	12	13	14	15	16	17	18	19	20
Relational	11	12	13	14	15	16	17	18	19	20
Functional Relational........................	11	12	13	14	15	16	17	18	19	20
Enactive Naming...............................	11	12	13	14	15	16	17	18	19	20
Pretend Self.......................................	11	12	13	14	15	16	17	18	19	20
Pretend Other....................................	11	12	13	14	15	16	17	18	19	20
Substitution Self................................	11	12	13	14	15	16	17	18	19	20
Substitution Other............................	11	12	13	14	15	16	17	18	19	20
Sequence No Story.............................	11	12	13	14	15	16	17	18	19	20
Sequence Story...................................	11	12	13	14	15	16	17	18	19	20
Sequence Subst. No Story..................	11	12	13	14	15	16	17	18	19	20
Sequence Subst. Story........................	11	12	13	14	15	16	17	18	19	20
Double Substitution...........................	11	12	13	14	15	16	17	18	19	20
TAPING TERMINATED..................	11	12	13	14	15	16	17	18	19	20

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QUALITY OF PLAY	21	22	23	24	25	26	27	28	29	30
Uncodeable: Blocked Vision............	21	22	23	24	25	26	27	28	29	30
Unfocussed..	21	22	23	24	25	26	27	28	29	30
Simple Manipulation.........................	21	22	23	24	25	26	27	28	29	30
Functional	21	22	23	24	25	26	27	28	29	30
Relational	21	22	23	24	25	26	27	28	29	30
Functional Relational........................	21	22	23	24	25	26	27	28	29	30
Enactive Naming.................................	21	22	23	24	25	26	27	28	29	30
Pretend Self..	21	22	23	24	25	26	27	28	29	30
Pretend Other.....................................	21	22	23	24	25	26	27	28	29	30
Substitution Self.................................	21	22	23	24	25	26	27	28	29	30
Substitution Other..............................	21	22	23	24	25	26	27	28	29	30
Sequence No Story..............................	21	22	23	24	25	26	27	28	29	30
Sequence Story....................................	21	22	23	24	25	26	27	28	29	30
Sequence Subst. No Story..................	21	22	23	24	25	26	27	28	29	30
Sequence Subst. Story........................	21	22	23	24	25	26	27	28	29	30
Double Substitution............................	21	22	23	24	25	26	27	28	29	30
TAPING TERMINATED..................	21	22	23	24	25	26	27	28	29	30

QUALITY OF PLAY	31	32	33	34	35	36	37	38	39	40
Uncodeable: Blocked Vision............	31	32	33	34	35	36	37	38	39	40
Unfocussed..	31	32	33	34	35	36	37	38	39	40
Simple Manipulation.........................	31	32	33	34	35	36	37	38	39	40
Functional	31	32	33	34	35	36	37	38	39	40
Relational	31	32	33	34	35	36	37	38	39	40
Functional Relational........................	31	32	33	34	35	36	37	38	39	40
Enactive Naming................................	31	32	33	34	35	36	37	38	39	40
Pretend Self..	31	32	33	34	35	36	37	38	39	40
Pretend Other....................................	31	32	33	34	35	36	37	38	39	40
Substitution Self................................	31	32	33	34	35	36	37	38	39	40
Substitution Other............................	31	32	33	34	35	36	37	38	39	40
Sequence No Story.............................	31	32	33	34	35	36	37	38	39	40
Sequence Story..................................	31	32	33	34	35	36	37	38	39	40
Sequence Subst. No Story..................	31	32	33	34	35	36	37	38	39	40
Sequence Subst. Story........................	31	32	33	34	35	36	37	38	39	40
Double Substitution...........................	31	32	33	34	35	36	37	38	39	40
TAPING TERMINATED..................	31	32	33	34	35	36	37	38	39	40

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CLEAN-UP TASK RATING SCALES*

I. Maternal Control and Affect

A. Sensitive Guidance
B. Overcontrol
C. Undercontrol
D. Positive Regard
E. Negative Regard

II. Child Compliance-Noncompliance and Affect

A. Compliance
B. Autonomous Noncompliance
C. Defiant Noncompliance
D. Passive Noncompliance
E. Positive Affect
F. Negative Affect

III. Dyadic Cooperation

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* Prepared by the Pitt-site (J. Belsky, C. Brownell, S. Campbell, & J. Cohn) and Timberlawn Foundation (M. T. Owen, B. A. Mulvihill, A. Ware, J. Mason, S. Wetzel) investigators and staff for the NICHD Study of Early Child Care Research Consortium, June 1993.

NOT TO BE USED WITHOUT PERMISSION OF THE STEERING COMMITTEE OF THE NICHD STUDY OF EARLY CHILD CARE

GENERAL INSTRUCTIONS FOR APPLYING THE CLEAN-UP TASK RATINGS

Each of the clean-up task ratings is based on a videotaped observation of the mother and her child during a clean up task lasting a maximum of 5 minutes. The procedure for this task is one in which the mother is instructed to involve her child in picking up the toys in the room. The mother is told that she can involve her child in any way that she chooses as long as the child participates in the clean-up.

In determining the ratings, it is helpful for the coder to take notes of the mother and child behaviors as they relate to each scale. The clean-up task worksheet, entitled "Observational Notes" is provided for this purpose. In assigning a rating, the coder may find it helpful to use a two-step decision making process. The first step is to ask, "Is this dimension 'characteristic' (4 or 5 rating), or 'not characteristic' (1 or 2 rating) of the person being rated?" In the event that the dimension is neither characteristic nor uncharacteristic, a mid-range rating of 3 is provided. Once this decision is made the coder can make the finer distinction between the 4 and 5 ratings or between the 1 and 2 ratings.

I. MATERNAL CONTROL AND AFFECT

Goals of ratings

During preschool years children must establish their autonomy while learning to accept limitations in line with parental socialization goals and the needs of others. The specific goal of the ratings of the mother in this section is to capture the extent to which and manner in which she helps the child to both establish autonomy and accept limitations in line with the parental socialization goal of cleaning up the toys. In providing appropriate control, the mother must be neither too overbearing (i.e., not allowing adequate autonomy), nor too permissive (i.e., providing inadequate amounts of direction, structure). Control which is too overbearing may reflect either hostile overcontrol or over-involvement that is positive in affective tone, but still does not provide the child sufficient opportunity to function independently. Undercontrol may reflect lack of engagement and involvement with the child or a misguided attempt to permit autonomy without limits placed on the child's expression of impulses and desires.

A. SENSITIVE GUIDANCE

This scale rates the degree to which the mother shows an awareness of her child's tendency to be compliant or non-compliant and the degree to which she tailors the initial instructions and follow-up behaviors appropriately.

> For children who are highly cooperative, this means being relatively nondirective, allowing the child to take the lead, and providing appropriate encouragement and praise.
>
> For children who tend to be less compliant, this means providing the appropriate amount of structure and guidance, but in a positive and clear (potentially firm), but non-hostile manner.

The sensitive mother is tuned in to the child's verbal and behavioral communications and responds appropriately to his/her need for autonomy, direction, structure, or self-direction.
Likewise, the sensitive parent shows an understanding of the child's mood and agenda, as reflected in verbalizations that validate the child's feelings or that are appropriately responsive and tuned-in to the child's ongoing behavior or desires (e.g., to continue playing rather than clean-up). In addition, the "tuned in", sensitive mother may anticipate trouble and skillfully redirect the child.

In her attempts to tailor instructions and support to the specific needs and behaviors of the child, the sensitive mother may use bargaining, game playing, negotiations, explanations, or suggestions to facilitate compliance and move the child along.

A sensitive mother is able to adjust her level of support based on her child's current level of ability.

> Speeches and lectures may reflect the parent's lack of understanding of the child's developmental level.
>
> Prohibitions that seem to be at the whim of the parent or that the child cannot understand are insensitive.

A sensitive mother may also model appropriate behavior (e.g., putting a toy away); offer help when the child seems to need it; or be responsive to the child's bids for assistance. However, sensitivity comes in appropriate doses; too much involvement in the form of negotiation, explanation, etc. may verge on overcontrol.

Compliance is not a necessary outcome of sensitive guidance.

SENSITIVE GUIDANCE RATINGS:

1. Not at all characteristic. No signs of maternal appropriate guidance are observed; the mother rarely responds appropriately to the child's cues and does not manifest an awareness of the child's needs. Entire episode is adult-centered.

2. Minimally characteristic. Mother displays few instances of appropriate guidance. For example, the mother only demonstrates one or two instances of appropriate guidance.

3. Sometimes characteristic. Mother shows some appropriate guidance, but it is mixed with inappropriate guidance about 1/2 of the time. Mother provides intermittent guidance. For example, the mother may start out very appropriate but "fizzles" toward the end of episode or she may be initially inappropriate but half-way through the episode begins responding in an appropriate manner.

4. Moderately characteristic. Mother shows multiple instances of appropriate guidance throughout the episode. Mother demonstrates appropriate guidance in most interactions but may neglect to give a full response. For example, in the case of a very compliant child, the mother allows child to work independently but neglects to provide appropriate praise.

5. Very characteristic. Mother is very tuned in to the child and aware of needs, agenda, etc., during the entire clean-up episode. Instances of inappropriate guidance are rare and never striking. For example, in the case of a very compliant child, a mother who provides appropriate praise and acknowledgement would receive this rating. For a noncompliant child, a mother who demonstrates consistent and positive guidance regardless of the non-compliance would receive this rating.

B. OVERCONTROL

This rating is meant to capture maternal behavior that is intrusive and overcontrolling, and that does not allow the child sufficient autonomy in completing the clean-up task.

Overcontrolling behavior is adult-centered rather than child-centered. The overcontrolling mother emphasizes her way of doing things rather than altering her behaviors or demands to fit the child's needs or abilities. The overcontrolling mother is not interested in letting the child pursue his/her own agenda, whether or not the child is on task.

Overcontrol is judged relative to the child's competencies and need for structure and assistance. In some cases, the mother may need to increase her level of control, e.g. offering more specific direction,in order to help her child accomplish the goal of picking up the toys.

Overcontrolling mothers do not allow the child to influence the pace or to make choices.

The overcontrolling mother may explicitly demand that the child pick up specific toys; may interrupt an appropriate or inappropriate activity or redirect the child, without allowing time for transitions or for the child to express his/her wishes or to take initiative in completing the task.

Overcontrol is independent of the quality of affect (which is rated separately), and may or may not be associated with negative affect and annoyance at the child.

Overcontrol may include threats and prohibitions.

Some mothers, however, are overcontrolling by simply doing too many seemingly good things. In these cases, an overcontrolling mother may give many commands or directives or a constant string of suggestions. She is constantly monitoring the child's behavior and progress on the task and directing his/her behavior:

This may include physically forcing or otherwise moving the child (e.g., taking chid's hands and making him/her pick up a particular toy.

OVERCONTROL RATINGS:

1. Not at all characteristic. Mother is not at all overcontrolling; provides appropriate level of control or allows the child autonomy.

2. Minimally characteristic. Instances of overcontrol are infrequent or weak. For example, the mother may display one or two instances of weak overcontrolling behavior but the balance is clearly in the direction of non-overcontrol.

3. Sometimes characteristic. Mother is overcontrolling for part of the time; is highly directive for portions of the clean-up, but also backs off and gives the child a chance to do the task independently or to pursue his/her own agenda for a portion of the time.

4. Moderately characteristic. Mother is predominantly overcontrolling throughout the episode. The mother is overcontrolling in most interactions.

5. Very characteristic. Mother is highly overcontrolling for most of the activity. She controls the interaction allowing the child little self-direction.

C. UNDERCONTROL

This rating is meant to capture maternal behavior that is insufficiently supportive and provides an inadequate amount of structure or scaffolding for the child's activities. Undercontrol may reflect maternal disengagement and lack of investment or a laissez-faire, overly permissive approach to the child's behavior.

Undercontrol involves providing an inappropriately low level of control because it is often appropriate to allow the child some degree of freedom in managing the situation. Therefore, like overcontrol, undercontrol is judged relative to the child's ability to accomplish the clean up task.

An undercontrolling mother lets the child do what s/he wishes; if the child continues to play with the toys, the mother may just sit and watch and say nothing; or totally let child take the lead without redirecting inappropriate task-related behavior to appropriate task-related behavior.

Other examples of undercontrol include the following:

> The child is off task for a prolonged period and parent fails to redirect the child.
>
> The child is making an effort and obviously needs help, but gets none.

An undercontrolling mother may miss or ignore the child's bids for help, signals of frustration, or difficulty in meeting the demands of the task.

Undercontrolling mothers may fail to exert adult control when it is appropriate or fail to follow through with stated intents.

UNDERCONTROL RATINGS:

1. Not at all characteristic. Mother is not at all undercontrolling; child may be very compliant and therefore require little control or when child is not compliant, the mother provides appropriate level of control.
2. Minimally characteristic. Instances of undercontrol are infrequent or weak. While the mother may be undercontrolling for a small portion of the episode, the balance is clearly in the direction of non-undercontrol. For example, the mother may let the child get off task occasionally, but more often promptly redirects the child's off-task behavior.
3. Sometimes characteristic. The mother is undercontrolling for part of the episode, letting the child do whatever s/he wants for too long, but if child continues to show no signs of cooperating, the mother eventually intervenes to redirect behavior.
4. Moderately characteristic. The mother is predominantly undercontrolling throughout the episode. If the child is non-compliant, the mother provides redirection (e.g., "you're supposed to be putting the toys away.") but only after a long period of off-task behavior on the part of the child. If the child is compliant, the mother exhibits very few monitoring behaviors.
5. Very characteristic. The mother is highly undercontrolling for the entire episode even when the child is not complying with the request to clean up the toys. If the child is compliant, the mother demonstrates NO monitoring behavior to the extent that she would not be able to recognize any need for direction. Even if there is minimal involvement, the mother appears to be "just going through the motions."

D. POSITIVE REGARD

This rating assesses the extent to which the mother displays warmth, nurturance, and positive affection toward the child and enjoys interacting with the child, with extent defined in terms of both frequency and intensity.

Behaviors that evidence such an orientation are numerous and diverse. Among others, they include:

> kissing and hugging the child;
>
> affectionately touching the child and smiling at and laughing with the child;
>
> being enthusiastically involved in what the child is saying or doing;
>
> general enjoyment of the child.

Especially important is the provision of praise and positive encouragement for cleaning up.

The ratings of positive regard and negative regard are independent of one another, That is, a low score on positive regard does not indicate anything about negativity, just that indications of positive regard are minimal.

POSITIVE REGARD RATINGS:

1. Not at all characteristic. Mother demonstrates no instances of warmth, affection, praise or enjoyment. She is instructional or uninvolved.

2. Minimally characteristic. **Very few** instances of warmth, affection, praise, or enjoyment are observed. Those that are observed are weak in their intensity.

3. Sometimes characteristic. **Some** instances of warmth, affection, praise, or enjoyment are observed. For example, the mother may laugh with her child, show some enthusiasm, or offer some praise. Instances may be weak in intensity yet consistent OR stronger in intensity yet occur less frequently.

4. Moderately characteristic. **Multiple** instances of warmth, affection, praise and/or enjoyment are observed. Instances are either moderate to high intensity yet less frequent, OR are very frequent but only weak to moderate in their intensity.

5. Very characteristic. Instances of warmth, affection, praise and/or enjoyment are very frequent and of a moderate to high intensity. The mother clearly delights in the child throughout the task.

E. NEGATIVE REGARD

This rating assesses the extent to which the mother displays hostility, negative affect, displeasure or annoyance toward the child, with extent defined in terms of both frequency and intensity.

Behaviors that evidence such an orientation are numerous and diverse. They include:

annoyed or scornful facial expressions and posturing

aggressive handling of the child

explicitly negative or scornful vocal tones

clear lack of enjoyment of the child in this situation

This scale measures negative affect and negative regard for the child and not negative affect alone.

NEGATIVE REGARD RATINGS:

1. Not at all characteristic. No evidence of hostility, negative affect or displeasure is observed.

2. Minimally characteristic. **Very few** instances of hostility, negative affect, or displeasure. Those that are observed are weak in their intensity.

3. Sometimes characteristic. **Some** instances of hostility, negative affect or displeasure are observed. Instances may be weak in their intensity yet occurring frequently OR a few instances of stronger negative regard are observed.

4. Moderately characteristic. **Multiple** instances of hostility, negative affect, and displeasure are observed. Instances are either moderate in their intensity yet occur more frequently OR weak in intensity yet occur quite frequently.

5. Very characteristic. Instances of hostility, negative affect, and displeasure are **very** frequent and are of moderate to high intensity.

II. CHILD COMPLIANCE-NONCOMPLIANCE AND AFFECT

Goals of ratings

One of the primary tasks of toddlers is to achieve autonomy in a social world that demands both independence and compliance. These ratings are meant to capture the frequency and quality of the toddler's compliance and noncompliance to parental requests. The ratings adopt a developmental perspective, recognizing that both compliance and noncompliance increase with age during the toddler years, and that both can be evidence of positive developmental change. In particular, noncompliance during the toddler years is viewed as evidence of the child's developing autonomy which can be expressed with specific and varying behaviors (Kuczynski, Kochanska, Radke-Yarrow & Girnius-Brown, 1987). There are also individual differences in both compliance and non-compliance, however, and too much or too little of either can be non-normative.

These ratings first identify how compliant or cooperative the child is with maternal requests and directions. When the child is noncompliant, the ratings also index 3 distinct forms of noncompliance that differ in the extent to which they indicate competent autonomous behavior: assertive noncompliance, defiant noncompliance and passive noncompliance. The assertive noncompliant and defiant noncompliant categories are explicitly defined. The category of passive noncompliance should be used as defined and whenever a noncompliant behavior does not clearly fit either one of these categories. Simple whining, fussing, or pouting will be captured in ratings of negative affect and are not in and of themselves non-compliant behaviors, but often indicate passive non-compliance.

For the coding of compliance and noncompliance, it is important to attend to the nature of the mother's instructions. In particular, note whether the mother's instruction is general (e.g. "pick up the toys" or "clean up the room") or explicit (e.g. "pick up that toy and put it in the basket"). Attention to this aspect of the instructions/directions will often help determine if any subsequent noncompliant child behavior is autonomous, defiant or passive.

It is also important to consider affect and accompanying behaviors to the child's noncompliance when determining the exact form of noncompliance. Certain behaviors such as taking a toy out of the basket can be any of the three forms of noncompliance depending on the broader context. Specific examples of such accompanying contexts and behaviors are provided under each category of noncompliance.

Finally, it should be recognized that not all of the child's behaviors need be viewed as either compliant or non compliant behaviors as when mother and child engage in brief interaction with the toys. Compliance and noncompliance will typically be judged in reference to general or explicit directions from the mother.

A. COMPLIANCE

This scale captures the degree to which the child willingly follows or cooperates with the mother's requests. This can happen in any of several ways:

> The child may be cooperative and comply immediately with the mothers directions.
>
> The child may have negotiated a satisfactory course of action that also coincides with the mother's wishes.
>
> The child may be about to do, or already be doing what the mother asks.
>
> The child may be fearful of the mother and complies to avoid punishment, threat, etc.

The rating takes into account the intensity, quality, or form of noncompliance, only the frequency of compliance/noncompliance throughout the entire episode. The end result of picking up all the toys does not necessarily suggest high compliance.
In other words, this rating includes a measure of how easy or difficult is it to get the child to cooperate with the mother's directions, requests, or demands.

COMPLIANCE RATINGS:

1. Not at all characteristic. Child **rarely** complies. Child is noncompliant even when the mother is firm or insistent. Noncompliance can take any form, but the child almost never complies, even after multiple attempts by the mother to achieve compliance. The child does virtually nothing of what is requested of him/her.

2. Minimally characteristic. **Very few** instances of compliance. Compliance is generally delayed, partial or occurs after great effort from the mother.

3. Sometimes characteristic. Child complies **some** of the time. This may occur because compliance is only achieved after several episodes of noncompliance or immediate compliance may be offset by 2 or more episodes of noncompliance, or by more frequent instances of weak noncompliance.

4. Moderately characteristic. The child is **predominantly** compliant; more compliant than noncompliant, but there are periods during the interaction when the child clearly does not comply with the mother's requests or demands.

5. Very characteristic. Child complies **nearly all the time immediately and willingly**. There is very seldom noncompliance, and noncompliance is weak or short-lived.

B. ASSERTIVE NONCOMPLIANCE (Autonomy)

This rating indexes the toddler's self-assertion and growing autonomy. It can be considered "realistic negativism" (Crockenberg & Litman, 1990). That is to say, it captures clear and reasonable attempts by toddlers to distinguish their own needs and desires from those of others around them, and their attempts to establish their independence and "selfhood."

Autonomy bids are not hostile, angry, or otherwise high in resistance or negative affect. They can be simple refusals to do what is requested, statements or explanations of the child's own preferences or desire, excuses, delaying tactics, or attempts to negotiate/argue.

The self-assertive child may be stubborn or persistent in the noncompliance, but there is not the sense of resistance for its own sake, or opposition out of anger at the mother or the situation.

Toddlers are often both autonomous/assertive and defiant. We will code defiance separately (see below). However, sometimes autonomy and defiance will occur in the same behavioral episode:

> For example, a child may deliver an assertive verbalization ("no") accompanied by angry affect. In this case, code the behavior as defiant, not as autonomous.
>
> Other times, though, autonomy and defiance will occur sequentially-- the child will start out being assertive, but with further pressure to comply from the mother, will become defiant. In this case, the child would receive scores for both autonomy and defiance.

Examples of assertive noncompliance:

Outright refusals when asked to do something: saying "no" or shaking head for "no"; "I won't"; "no, thank you."

Statements/explanations of own preference or desire: "I don't want to"; "I want to play"; "I don't like to"; "I don't feel like it."

Excuses/Delaying tactics: "I'm too tired"; "I can't"; "I'm too little"; "I'm still playing."

Negotiation attempts: "Why?"; "You do it"; "I'll do it later"; "Do I have to?"

Nonverbal attempts: Nonverbal attempts at assertion may take the form of shaking the head to indicate "no." There may also be other indicators of assertion that are not verbal, but they must convey an attempt to communicate "no" to the mother.

ASSERTIVE NONCOMPLIANCE RATINGS:

1. Not at all characteristic. Child **never** exhibits autonomy bids or is never self-assertive. Child always complies or noncompliance never includes autonomy bids or self-assertion.

2. Minimally characteristic. **Very few** instances of autonomy bids/self-assertion. Instances are infrequent or weak. One or two instances of mildly autonomous/self-assertive behavior are observed.

3. Sometimes characteristic. **Some** instances of autonomous/self-assertive noncompliant behavior are observed. Child appears to be moderately autonomous or self-assertive part of the time.

4. Moderately characteristic. Child is **predominantly** autonomous/self-assertive in interactions with the parent leading to partial, delayed, or total noncompliance. The child frequently displays moderate autonomous/self-assertive behavior or speech OR exhibits several very clear, strong instances.

5. Very characteristic. Child is **exceptionally** autonomous in interactions with the mother. There is consistent, clear, strong self-assertion from the child in addressing maternal requests or demands.

C. DEFIANT NONCOMPLIANCE

This rating indexes the toddler's hostile, angry or affectively negative resistance or opposition to the mother's requests for demands.

This is more than simple unwillingness to comply, or a desire to differentiate oneself from the rest of the social world. It is "negativism for its own sake" (Crockenberg & Litman, 1990).

The child's defiant behavior is in response to a maternal request and seems primarily directed toward resisting or antagonizing the mother. Defiant noncompliance is less competent, more impulsive, more intense and often more persistent than autonomy.

Defiance includes doing exactly the opposite of what is requested, intensifying the behavior that is "off limits," and angry or aggressive responses to requests, including yelling, throwing things, stomping feet, biting and kicking, having a temper tantrum, etc.

If a verbalization that might be considered an autonomy bid ("No," "I don't want to") is delivered with anger, it is defiance.

Taking a toy out of the basket: When a child takes a toy out of the basket, it is coded as defiance if it is accompanied by negative affect and/or a clearly defiant action (e.g. slamming) or clearly defiant "oh, no I won't!" look directed toward the mother. Otherwise it is coded as either assertive noncompliance or passive noncompliance depending on the accompanying affect and other behaviors.

DEFIANT NONCOMPLIANCE RATINGS:

1. Not at all characteristic. Child is never defiant. Child may always comply OR noncompliance never takes the form of defiance.

2. Minimally characteristic. Child exhibits weak or infrequent defiant behavior. Only a few instances of mildly defiant behavior are observed.

3. Sometimes characteristic. Some instances of defiant noncompliant behavior are observed. Child appears to be moderately defiant part of the time.

4. Moderately characteristic. Child is predominantly defiant; exhibits frequent low intensity defiance, and/or exhibits several strong instances of defiance.

5. Very characteristic. Child is exceptionally defiant. There is consistent, intense defiance in response to parental suggestions, requests, directives, and/or demands. The entire episode is characterized by defiance. Defiance is a clear and consistent style of responding to maternal requests.

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D. PASSIVE NONCOMPLIANCE

While both autonomy bids and defiance are active forms of noncompliance in which children make their unwillingness to cooperate with maternal requests unequivocal, passive noncompliance is just that. The child fails to comply but does so without overt defiance or refusal. In general, a noncompliant behavior which is clearly not autonomous or defiant is coded as passive noncompliant.

This will mostly take the form of ignoring the request.

It also includes changing the subject or changing activity to one not requested (e.g., playing with a different toy is passive noncompliance).

Taking a toy out of the basket: In some cases, the child may look to the basket in response to the mother's clean-up request, notice a toy in the basket and take that toy out either examining it, playing with it or laying it aside. In such cases taking the toy out of the basket is coded as passive noncompliance since the child is passively exploring or playing with the toy as if ignoring the mother's request. In such cases, defiance or assertiveness cannot necessarily be implied.

PASSIVE NONCOMPLIANCE RATINGS:

1. Not at all characteristic. Child is never passively noncompliant. Child always complies or noncompliance takes other forms.
2. Minimally characteristic. Child exhibits brief and infrequent passive noncompliance. No more than one or two instances of passive behavior are observed.
3. Sometimes characteristic. Some instances of passive noncompliant behavior are observed. Child exhibits passive noncompliance in approximately half of the interactions.
4. Moderately characteristic. Child is predominantly passively noncompliant. Child exhibits frequent instances of passivity.
5. Very characteristic. Child is exceptionally passively noncompliant. The child never overtly defies or refuses, but rather ignores or diverts attention away from the issue directed toward compliance. Passive noncompliance is a clear and consistent style of responding to maternal requests.

E. POSITIVE AFFECT

This scale assesses the degree to which the child is obviously happy and having fun.

The best indicators of this are:

facial expressions (laughs, smiles, etc.)

tone of voice

A child high in this scale clearly would be having a good time, with spontaneous and zestful expressions of fun, delight, and bubbliness. The child would display multiple indicators of positive affect.

A low score on this scale does not indicate anything about overt negativity; scale scores reflect the frequency and strength of positive expressions.

POSITIVE AFFECT RATINGS:

1. Not at all characteristic. Child exhibits no explicit indicators of positive affect. Child is sober, flat, expressionless or negative.
2. Minimally characteristic. Child exhibits **weak or infrequent** indicators of positive mood. No more than one or two instances of mildly positive behavior are observed. The child may be businesslike or pleasant without any strong signs of positive mood. The child appears content throughout the episode.
3. Sometimes characteristic. **Some** evidence of pleasure is apparent via laughs, smiles, etc., but about one-half of the time child is either neutral, negative, or a mixture.
4. Moderately characteristic. Child is **predominantly** positive exhibiting a fairly high variety of indicators characterized by some intensity. Several instances of strong affect are observed and the child is pleasant and content most of the rest of the time.
5. Very characteristic. Child is **exceptionally** positive. Child displays multiple instances of strong positive affect. Child should truly "radiate" or sparkle and show no signs of strong distress or negativity.

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F. NEGATIVE AFFECT

This rating assesses the extent to which the child is distressed, angry, hostile, or in some other way manifests unhappiness and displeasure.

Behavior that evidence such an orientation are numerous and diverse, and include:

> crying, pouting, throwing objects, stomping feet, yelling, screaming, sneering and the like.

In making this rating both intensity and frequency should be taken into consideration.

NEGATIVE AFFECT RATINGS:

1. Not at all characteristic. Child is **rarely** negative. If only 1 mild instance occurs, a "1" may still be scored. No evidence of strong negative affective expression is displayed.
2. Minimally characteristic. Child exhibits **weak or infrequent** negative affect. No more than one or two instances of mildly negative expressions are observed. Instances are weak and brief.
3. Sometimes characteristic. Child appears to be **moderately** negative in terms of frequency and intensity. During approximately half of the interactions, some type of negative expression is observed. This behavior should not escalate into an extensive display, i.e., instances are somewhat isolated behaviors.
4. Moderately characteristic. Child is **predominantly** negative. Variety and intensity of indicators is fairly high. One or two instances of strong negative affect are observed OR the child is moderately negative throughout the episode.
5. Very characteristic. Child is **exceptionally** negative. Child frequently or markedly displays anger and/or hostility, several instances of strong negative affect and is rarely contented or pleasant.

III. DYADIC COOPERATION

This rating is meant to capture the extent of mutuality, cooperation, connectedness, reciprocity and smoothness of interaction between the mother and the child during the clean-up task. Dyadic cooperation takes into account both the mother's and the child's contributions as they work to accomplish the task.

In cooperative dyads, the mother and the child are both attending to the task. The actions of both the mother and the child are contingent upon one another. Their interactions are smooth and show no evidence of power struggles or conflict.

> When the mother makes a suggestion, the child responds with a look, verbalization or compliance.
>
> If the child does not respond or comply, the mother either follows the child's action or tries a new request.
>
> Turn taking with back and forth exchanges is evident.
>
> Turn taking and responses are exhibited without insistence or hesitation

In cooperative dyads, the entire episode is characterized by reciprocity and smoothness. There is a sense of familiarity between the mother and child. They appear to be consistently synchronous. The dyadic system is efficient and effective in working toward solving the task.

In cooperative dyads, the mother may be sensitive yet still have a non-compliant child as long as the actions of both are reciprocal and complementary.

In non-cooperative dyads, the mother and child are clearly following two different agendas around the clean-up task.

> The mother may persist with a general direction while the child ignores or persists with a noncompliant behavior.
>
> The child and/or mother may engage in non-communicative, egocentric speech without acknowledgement of the other's statements.
>
> The child may initiate off-task or noncompliant behaviors which are responded to asynchronously (Rocissano & Slade, 1987) by the mother (e.g. the mother redirects to a different off-task behavior; the mother does not acknowledge the child's assertive action; or the mother ignores the off task behavior).

DYADIC COOPERATION RATINGS:

1. Not at all characteristic. There is **almost no** dyadic cooperation during the entire episode. Mother-child conflict is very high OR there is little interaction or interchange between them.

2. Minimally characteristic. **Very few** instances of dyadic cooperation are observed. Most of the interaction is characterized by a lack of cooperation and synchrony.

3. Sometimes characteristic. Instances of dyadic cooperation and synchrony are evident in the interactions for **about one half** of the episode.

4. Moderately characteristic. The dyad is **predominantly** cooperative and "in sync" with few periods lacking cooperation. The interaction exhibits more mother-child cooperation than lack of it, but there are occasional periods when the dyad is not "in sync" with one another.

5. Very characteristic. The dyad is **exceptionally** cooperative and positive. The entire segment is characterized by mutual cooperation, turn-taking or give-and-take interchanges, and a positive tone.

Chapter 23

Section 3

24 MONTH BAYLEY SCALES OF INFANT DEVELOPMENT (MDI)

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Chapter 23

Section 3

24 MONTH BAYLEY SCALES OF INFANT DEVELOPMENT (MDI)

I. OVERVIEW

The Manual for the revised Bayley Scales of Infant Development (Psychological Corporation) is quite comprehensive. These materials will serve as the basic manual, with additional instructions provided in this chapter.

Revised Bayley kits were provided to all sites by Psychological Corporation.

II. PREPARATION FOR THE TRAINING

Examiners should begin preparation for the training three months ahead of time. The following steps should be taken:

A. Read the manual several times, paying special attention to the instructions for administering items. It is especially important that examiners be thoroughly familiar with how items are administered and scored. Because of the possible wide range of age and ability testers may encounter during data collection, testers must be knowledgeable about items numbered from 115 to 186, although most tests will include only a fraction of those items. Some information regarding rapport with children and the general principles on which the Bayley was constructed are available in the earlier version of the Bayley manual, and should be read by new examiners.

B. New examiners should observe a trained examiner administer a Bayley to a 24 to 30 month old child. A training tape showing the revised Bayley being administered has been provided to all sites by the Kansas site. This tape should also be reviewed by all testers.

C. Before sending tapes for certification, examiners should administer a minimum of TEN practice tests each to children ranging in age from 23 to 30 months. If two examiners are training together (the recommended procedure), this means a total of 20 Bayley tests, with each trainee administering 10 and observing 10. If a skilled examiner is available at the site, he or she may be asked to observe each trainee or review tapes of one of two sessions. Be sure this examiner is familiar with the special instructions for administering the Bayley, specific to this study, included in this manual.

During practice, testers should be sure to get experience with presenting all the items numbered from 115 to 186, even if these are outside the range of competence for the child being tested. It is not necessary that every practice test be a complete test, but that the examiner get experience with all the possible items that will be used during data collection.

III. TRAINING

Training was provided in one-half day during the lab training session for 24 months at the Pittsburgh site. Training on the new Bayley was conducted by a representative of the Psychological Corporation.

IV. BECOMING A CERTIFIED EXAMINER

After administering at least ten practice tests, examiners will videotape themselves administering the Bayley to two children between 23 and 29 months of age. Each examiner will then use the Bayely Self-Monitoring Form to review his/her own performance. The tester should determine whether the test meets criterion -- **no more than 1 error in general test procedures and errors in administration or scoring on no more than 2 items.** Tapes used for certification also must be complete tests; that is, there should be no omitted or refused items.

If the tester believes the taped test meets criterion, the videotape, the Bayley score sheet, the compliance score sheet, and the self-monitoring form should be sent to the Kansas site, identified by tester ID number. The tape and score sheet will then be reviewed by trained personnel at the Kansas site. The tapes will be scored and the examiner certified if the criteria are met for two tapes. If the test does not meet criterion, specific feedback will be sent to the site coordinator who is responsible for providing additional training opportunities for that tester. Two tests must meet criterion for an examiner to be certified.

Once an examiner is certified, rechecks by the Kansas site are not required. It is useful, however, for examiners to continue to use the self-monitoring form once a month to check their own performance. Site coordinators are responsible for reviewing these self-checks.

V. SPECIAL ADMINISTRATION INSTRUCTIONS FOR THIS STUDY

For information about details of particular item administration, refer to the revised Bayley manual and the Bayley Self-Monitoring Form included in an appendix to this manual.

A. TESTING SITUATION

The Bayley will be administered in the lab after the clean-up session. It is preferable for the child to be seated in a high chair (without the tray) or in a Sassy Seat at an adult-height table that is at least 2' x 3'. The mother should sit to the child's side and the examiner should sit directly facing the child across the table.

All examiners are expected to begin their tests with the child seated at an adult-height table. When attractive materials are provided for the child before he or she is seated, and the examiner focuses his or her attention directly on the child (rather than on the mother), it is usually possible to get past the difficult transition into the high chair or Sassy Seat.

If the child becomes extremely fussy or is unable to be settled, the Bayley can be given in other situations. Try these in this order: (a) child seated on mother's lap at the adult-height table; (b) child seated in a child-sized chair at a child-sized table, with the mother and examiner also at child height; and (c) on the floor.

B. EXPLAINING THE BAYLEY TO THE MOTHER

Prior to beginning the Bayley, it is necessary to explain what will happen to the mother so she knows what is expected of her in the testing situation. Rather than take up valuable testing time doing this explanation, it is recommended that the explanation be given during Solitary Play or at some other point in the lab session. The beginning of the testing situation is an important one in establishing rapport between tester and child; testers who must divert their attention to the mother at this point are likely to lose the child's interest and attention.

A suggested script for introducting the Bayley follows:

> "I will be presenting game-like tasks to your child. For example, I will ask her to stack blocks, to put some pegs in a board, and to name some pictures. Some of the things I give her will be too easy, some will be too hard, and some will be just right. Please try not to talk to your child while we're doing this because I want her to pay attention to me. This may be hard for you, especially if she doesn't do some things you know she can do, or if she

surprises you by doing some new things. I think you will really enjoy watching this part of the visit."

During the test, it is acceptable for the examiner to ask the mother to present items if the child refuses to do them for the examiner. This procedure is discouraged, however, because it tends to involve the mother too actively in the testing. If the tester feels it is necessary to involve the mother, this should be done at the conclusion of the assessment, when the examiner has already obtained as much information and scoring as he or she can without the mother's involvement.

If a mother is intrusive or tries to interact with the tester or the child, the tester should repeat the instructions already given. A tester might say:

> "I need to have CHILD pay attention to me. I'll let you know when to help. Otherwise, I'd appreciate your not talking right now."

If a mother asks the tester about the results of the assessment, or asks for a score or her child's IQ, the tester should say:

> "This is a new measure that has not yet been standardized. We use it to get a picture of your child's abilities as compared with other children his/her age. There's really no way to figure out a score on this measure."

If a mother is particularly insistent, testers might continue:

"I am not qualified to interpret the results of any of the measures we use in this study. I would be happy to ask SITE COORDINATOR or PRINCIPAL INVESTIGATOR to give you a call in the next day or two to talk more about the study."

C. ITEMS TO PRESENT

The standardization version of the revised Bayley provides for a single set of items to be presented at each age level. For the purposes of the NICHD Study of Early Child Care, it is important that we determine a child's actual level of performance. Therefore, we have established basal and ceiling levels of performance determined by children's passing or failing 4 of 6 items in particular item sets. This kind of criterion is necessary because the standardization version of the revised Bayley does not have the items ordered in a way that permits establishment of a basal and ceiling based on consecutive item passes or failures.

For all children, the set of items that should be used initially to determine the basal includes items numbered 128 to 133, and the items initially used for the ceiling are 157 to 162. If a child does not pass 4 of the 6 items between 128 and 133, the tester must administer items 122 to 127, and the child must pass at least 4 of those 6 items. If the child still does not pass 4 of 6 items, the tester must continue working downward in sets of 6 until the child passes 4 of the 6 items in the set. A similar procedure is to be used with the items making up the

ceiling. To establish a ceiling, a child must fail 4 of 6 items in a set. The initial ceiling set for children in the regular window is items 157 to 162. If a child passes more than 2 of these items, continue by presenting items 163 to 168. Again, if a child passes more than 2 of these items, move to the next item set (presenting item 169 but omitting it from calculation of a ceiling because it is very easy) of 170 to 175. If a child passes more than 2 of these 6 items, continue to administer the next item set of 176 to 181. Thus, the child must fail 4 items in a set in order to establish a ceiling.

Suggestions for the order in which to present items to children are included in the next section.

Testers must remain flexible in their selection of items and continue to test until a basal and ceiling are established. At the same time, it is advisable that the time of testing be kept under 30 minutes if possible, and definitely under 40 minutes. Thus, it is important that a tester determine the child's basal and ceiling levels early in the assessment, so the majority of the time can be spent determining the child's abilities within that range. The order of items presented in the next section of the manual will allow testers to determine at the outset of the assessment whether the child will fit within the standard set of items.

D. ORDER OF ITEMS

A suggested order of items for 24, 27, and 30 months is provided in the Bayley manual. These orders tend to move from easy to difficult items, and may lead to problems in maintaining the child's interest toward the end of the test.

Following is a different order of presenting items that is suggested for use in the NICHD Study of Early Child Care. Examiners are not required to use this suggested order, but may develop an order of presentation that works well for them, as long as easier and more difficult items are interspersed throughout the test. It is not acceptable for testers to go through the Bayley items in numerical order.

The advantage to using the order suggested here is that it allows testers to establish basal and ceiling levels of performance for children at the outset of the test, thereby saving time and child patience.

If the child does not reach ceiling on items 170 through 175, the tester should intersperse items in the next highest set (items 176-181) between easier items so that the child is never presented with a long series of difficult items. All testers should be thoroughly familiar with the correct presentation of items from 122 through 187.

SUGGESTED ORDER OF PRESENTING ITEMS

EXPECTED RANGE OF ITEMS #128-162
BASAL #128-133 (a basal is established if a child passes 4 of 6 items; items labeled (B) in the list below are in this range)
CEILING #157-162 (a ceiling is established if a child passes no more than 2 of 6 items; items labeled (C) in the list below are in this range
* marks optional items below or above the expected basal and ceiling for children in this age range; administer only as necessary to establish a basal or ceiling

		Pegs
(B)	130	Places Pegs in 30 Seconds
	143	Sorts Pegs by Color
		Blue Board
	139	Blue Board in 150 Seconds
(C)	159	Blue Board in 90 Seconds
	126*	Places 4 Blocks in 150 Seconds
		Stimulus Booklet
(C)	157	Discriminates Pictures I
(C)	158	Discriminates Pictures II
		Pink Board
(B)	129	Completes Pink Board
	137	Completes Reversed Pink Board
(C)	160	Recalls Geometric Forms
		Crayon and Paper
	148	Imitates Vertical and Horizontal Strokes
	116*	Imitates Stroke
(B)	128	Differentiates Scribble from Stroke
		Blue Boxes
(C)	161	Compares Masses
		Cubes
	140	Builds Tower of 6 Cubes
	117*	Builds Tower of 2 Cubes
	166*	Builds Tower of 8 Cubes
	165*	Understands Concept of One
	163*	Repeats 3 Number Sequence
	167*	Builds Bridge
	168*	Builds Wall
	169*	Helps Put Blocks Away

Stimulus Booklet

146	Names Five Pictures
120*	Names One Picture
138	Matches 3 Colors
154	Matches 4 Colors
147	Displays Verbal Comprehension
164*	Compares Sizes
173*	Discriminates Patterns
174*	Discriminates Sizes
175*	Names 4 Colors
156	Identifies 3 Incomplete Pictures

Objects

150	Names 3 Objects
123*	Names 1 Object

Book

171*	Attends to Story
170*	Produces Multiple Word Utterance in Response to book

152	Builds Train of Cubes
141	Identifies Objects in Photograph
155	Understands 2 Prepositions
172*	Completes Patterns
149	Discriminates Book, Cube, Key
144	Nests 4 Cups
142	Places Beads in Tube
122*	Finds 2 Objects
124*	Points to 3 Parts of Doll
121*	Follows Directions, Doll
118*	Retrieves Toy (Invisible Displacements)
119*	Retrieves Toy (Plexiglas Box II)

E. SCORING THE INCIDENTALLY OBSERVED LANGUAGE ITEMS

The portions of the laboratory session that can be used to score the language items that are observed incidentally are **the cleanup and the actual Bayley administration.** The items that are to be observed incidentally are marked with an asterisk in the score sheet. Testers should indicate in the Comments column of the score sheet what the child said that is being scored.

These items cannot be scored by parent report or by report of other members of the lab team, but only if they were observed by the examiner.

The incidentally observed language items (those marked with an asterisk on the score sheet) are the only Bayley items that can be scored outside of the testing situation. If you observed a child doing something during snack or solitary play that is part of the Bayley, and cannot get that performance during the assessment, that item cannot be scored a pass on the Bayley. It is possible to present a few Bayley items later in the lab session if necessary to complete a test, but testers must be careful to present these items according to the manual instructions.

F. MAINTAINING CHILD INVOLVEMENT

The pace at which the tester presents items to the child is important in maintaining the child's interest and involvement. This pace should be adjusted to the individual child, but in general must be more rapid than an "ideal" interaction between an adult and child. Testers should remember that the Bayley is not an opportunity for children to explore materials, but an assessment of the child's developmental status. It is better to move to the next item before the child is tired of the current one. If the child protests, he or she can maintain possession of one toy while the tester present the next, and once his or her attention has shifted to the new toy, the tester can gently remove the previous one from his or her hand. Items that are timed or that may require the child to use both hands should not be presented until the previous materials are removed.

If a child seems to be getting frustrated, it may be helpful to give him or her an attractive material to manipulate and explore for a minute or two before going on to the next item. The bell is sometimes attractive to children, as is the book. Testers must remember that this takes time, however. A better strategy is to alternate easy and difficult items to maintain the child's involvement.

Enthusiasm on the tester's part is also important. Your positive affect and emotional involvement are contagious. It is especially crucial that the tester's enthusiasm not vary with the child's success on particular tasks. Thus, the tester must be just as likely to say "Good job" or "Nice work" when the child fails an item as when the child succeeds, as long as the child's attempts are directed toward the task. If the tester is not able to do this, he or she should avoid using these phrases. In all cases, praise should be kept general and not include specific feedback. Avoid saying, "You got all the pegs in the board" or "You stacked five of them" or even "That's right." Instead, focus on the child's effort or the attractiveness of the materials: "Great try" or "This is fun" or "You're working hard."

When testers review their tapes using the Bayley self-monitoring form, they should listen to their own verbal responses to the child's performance and work to be sure they are not providing differential feedback related to the child's success.

Sensitivity to the child also means that testers have to make decisions about removing materials when the child is finished with them, even if the specified time has not been reached. The timings in the Bayley manual are primarily for standardization purposes and do not have to be followed rigidly. It is important, however, that testers not interrupt a child in the midst of completing a task, or take materials away without giving a child an opportunity to pass an item.

Testers should be thoroughly familiar with the criteria for each item so that items can be abbreviated if the child either passes the item before all parts have been presented or fails one part of a multi-part item on which all parts must be passed for credit. Because the revised manual was written for standardization, testers should read administration and scoring instructions carefully, and omit administration of portions of items not needed for scoring.

For example, Item 149 requires that a child discriminate book, cube, and key. If a child fails one of the three, the other two do not have to be presented. Similarly, for Item 154, Matching Four Colors, if a child fails the first two, there is no way he or she can match four. On Item 141, Identifies Objects in Photograph, once a child has identified 2 of the objects, the child passes the item and the remaining objects do not have to be asked. Testers can gain substantial time by not presenting unnecessary portions of items. Testers should also note that although the instructions for Item 146 include having the child point to pictures he or she did not name, the pointing is not scored anywhere in the test and therefore should be omitted.

G. SCORING THE BAYLEY

On the face sheet of the Bayley score sheet, record only the following items:

a) child's ID number

b) tester's ID number

c) test date

d) birth date

e) child's age (in months and days)

f) time of day test begins and ends (include a.m. or p.m.)

Record the child's performance on each appropriate item in the column labeled Scoring. Instead of C/NC, score P (pass) or F (fail) to keep our scoring consistent from 15 months. Use the Comments column to help you remember what the child does, and also to record incidentally observed language items. In many cases, the information requested in the Comments column is not required. An accurate record of items Passed and Failed is most important, along with a record of the language items.

A test is considered complete if a basal and ceiling have been established and there are no more than two items omitted or refused between them. In the Scoring column, score omissions as O and refusals as R. Refusals are determined by the child's behavior; that is, the tester presents an item but the child refuses to touch the materials or touches them only to push or throw them away. Omissions are determined by the tester's behavior; he or she simply does not present the item. It is not acceptable to score an item a refusal because the tester thinks the child will not do it. The item must be presented. Parent reports of child performance can be recorded in the comments column but cannot be used to score a Pass.

In some cases, if only a few items are missing, it may be possible to complete the test at the end of the lab session while the mother is being interviewed and is filling out questionnaires. Sometimes the intervening break and new situation makes a child more willing to try tasks. If a large number of items have been omitted or refused, however, it is better to reschedule for another time, because the child's performance is probably below his or her usual level due to illness or tiredness.

If a test is not completed, the child must be rescheduled for another lab session. If the lab session cannot be scheduled, it is possible to give the Bayley in the child's home or child care setting if an appropriate testing situation can be devised. Incomplete Bayley scoring sheets should NOT be sent to the DCC.

E. WHAT TO DO IF A CHILD DOES VERY POORLY ON THE BAYLEY

The new Bayley is not yet standardized, and therefore we are not able to calculate scores at this time. The Psychological Corporation suggests that if a child in the age range we are testing fails items 126 through 131, they are in the lowest 25% for their age. (Note: if a tester finds a child fails these items, he or she should continue testing using easier items to establish the child's developmental status.)

Should a tester find that a child does very poorly on the Bayley and appears to have developmental problems, he or she should bring this to the attention of the Site Coordinator and Principal Investigator at his or her site. They can review the entire laboratory session along with other information and make a determination about the need for discussing possibilities for further developmental evaluation with the parent.

VI. CODING COMPLIANCE DURING THE BAYLEY

In addition to presenting and scoring Bayley items according to the manual, testers in the NICHD Study of Early Child Care will also score some items in terms of the child's willingness to comply with your verbal directions. Compliance is independent of the child's ability to complete the task; it simply measures the child's willingness to try in response to your verbal instructions.

Compliance will be scored on a separate coding sheet, but compliance tasks will be administered during the Bayley itself. There are five sets of materials on which compliance is to be scored: the blue board, the cubes, the crayon and paper, the pegs, and the nesting cups. During the assessment, testers can either indicate the child's compliance with requests in the Comments column of the Bayley score sheet or on the separate compliance coding form. If the Bayley score sheet is used, testers must remember to transfer their compliance scores on these tasks to the compliance coding form after the completion of the lab session.

For each compliance item, consider the child's behavior in the 10 seconds immediately following your request. Each request can be repeated once (a total of 2 requests) if the child does not comply immediately. After the second 10 second period, continue with the Bayley. Do not make multiple requests or delay the test in order to pursue compliance. Also, score the child's first response. If a child complies initially, then appears to resist or pull back, score compliance. If a child complies with the first request, it is not necessary to repeat the request a second time. The intent is to make the compliance requests a natural part of the Bayley procedure. These requests should not add significant time to the administration of the Bayley.

The five items on which compliance is scored include two types of compliance: the child's willingness to attempt the task and the child's response to your request for the materials. The child's willingness to attempt the task can be assessed within the typical presentation of the items. In other words, when you set out the blue board, you hand the child a block and say, "Put the block where it goes." The child will be scored as compliant if he or she takes the block from you and attempts to put it in the board; as non-compliant if he or she refuses to relinquish the toy or pushes the board onto the floor. Sometimes a child will say "No" or shake his or her head but hand you the toy or try the item as you have requested; the child's behavior, not his or her language should be scored. Thus, a child who says "No" but physically complies is scored as complying.

At the end of each item presentation, when you have scored the child on passing or failing the item, you make a specific request for him or her to give you the materials. You should say, "It's time to clean up. Please give me the TOY." Do not hold out your hands. Wait 10 seconds for the child to respond. If the child pushes the materials toward you or lifts them up in your direction, score the child as compliant with your request and move to the next Bayley item. If the child does not respond in a compliant way within 10 seconds, repeat your request. Wait 10 seconds again. If the child still does not comply, score the child as non-compliant on that request and move to the next Bayley item. It is not necessary to use a timer to judge the 10 second interval; counting 1001, 1002, etc. is close enough.

If the child has pushed the toy away before your request, gently replace it in front of the child and then ask the child to give it to you. Remember that it is not necessary for the child to comply; there should be no power struggle between you and the child and no lengthy negative interaction.

The items on which compliance is scored and the specific compliance tasks are:

126/139/159 Blue board

1. Does the child try to put any of the blocks into the blue board (takes at least one block in his/her hand and places it somewhere on the board, not necessarily in the correct place)?

2. Does the child try to put all of the blocks into the blue board (takes each block in turn in his/her hand and places it somewhere on the board)?

3. Does the child comply with tester's request for the blocks and board at the end of the task?

128/148 Crayon and paper

1. Does the child use the crayon on the paper (rather than sticking it in his/her ear or scribbling on the table) and try to follow the examiner's directions (makes marks on the paper) within 10 seconds of the request, even if he or she cannot imitate the strokes exactly?

2. Does the child comply with tester's request for the crayon and paper at the end of the task?

130 Pegs

1. Does the child put any of the pegs in the pegboard (picks up at least one peg and places it in a hole)?

2. Does the child put all the pegs in the pegboard (not necessary for child to succeed in placing all pegs within a certain time to be scored as compliant)?

3. Does the child comply with tester's request for the pegs and pegboard at the end of the task?

140/166 Stacking Cubes

1. Does the child try to build a tower of any size even if he or she cannot stack 6 or 8 cubes?

144 Nesting cups

1. Does the child try to nest the cups even if he or she cannot succeed at the task?

2. Does the child comply with tester's request for the cups at the end of the task?

152 Train of cubes

1. Does the child try to make the train at tester's request?

2. Does the child comply with tester's request for the cubes at the end of the task?

VII. BAYLEY MATERIALS

The toys in the Bayley kit need to be washed thoroughly between each use, whether or not children put them in their mouths. The best routine for washing toys is to put them in soapy water, then rinse in clear water, then dip in a solution of 1 tsp chlorine bleach mixed with 1 gallon water. Then they should be dried thoroughly with clean towels. Some Bayley materials cannot be soaked in water. These should be wiped with a bleach solution or other disinfectant. The book, stimulus booklet, and other cardboard materials need careful treatment. Some of them are not well coated and cannot stand much wetness. For these, be sure they are thoroughly wiped clean after each use.

While you are testing, be alert to what children are putting in their mouths. Try to retrieve the pegs and crayon before they go into children's mouths. Also be careful with the plastic bags used for peg sorting. The pencil in the kit, which should be sharpened for use in testing, also needs to be watched carefully.

APPENDIX A

SELF-MONITORING FORM FOR THE 24-MONTH BAYLEY

APPENDIX B

THE BAYLEY SCORE SHEET

APPENDIX C

THE COMPLIANCE CODING SHEET

Chapter 23

Section 4

SNACK

The purpose of the snack is to provide mother and child a break before continuing with additional procedures. Initial descriptions for this procedure were developed by Cathryn Booth. Revisions to the procedure were made by Deborah Vandell following comments and piloting by Temple, Pittsburgh, Washington, Wisconsin, and Western Carolina.

I. **MATERIALS**
   A. An adult-sized chair
   B. A child size table and chair
   C. A tray containing:
      a. child cup with lid
      b. paper cup for the mother
      c. Cheerios in a small Tupperware container
      d. one individually wrapped slice of American cheese
      e. snack sized box of raisins
      f. several crackers in a small Tupperware container
      g. napkins
   D. Bottle of unsugared apple juice (enough for mother and child) that is of a size that the child can pour if mother permits him
   E. Baby wipes for cleanup

II. **PROCEDURE**

At the end of the Bayley testing, say to the mother, "Now it's time to take a break and have a snack. I have a table and chairs here for you and CHILD." Then say, "Here's the snack on this tray. Go ahead and have some yourself. Let me know when you are finished."

The visit coordinator should then quickly leave. The snack segment can continue until the mother and child have finished or for 10 minutes. The visit coordinator should observe the snack from behind the one way glass. When it appears that the snack is finished, s/he should go into the room and remove the remains of the snack, as well as table and chair for child unless they are to be used for site specific activities. If 10 minutes have elapsed, the visit coordinator should encourage the mother to "finish up" so that the visit does not become too long.

Although there are no current plans to code the snack as part of the common protocol, all sites should videotape the snack session and send it along with the solitary play procedure to Seattle. Videotaping should begin when visit coordinator, mother, and child enter the playroom. During the snack, the video image should include both mother and child, if at all possible. The table and chairs for the snack should be arranged so as to maximize the opportunity to have both the mother's and the child's faces on the screen as well as bodies. If it is not possible to get both mother and child on the screen, focus on the child with regular "scans" back to the mother. While filming, adjust the lens so that the images of mother and child fill most of the screen. Pictures of the carpet or the cracker will not help coders in the future!

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Chapter 23

Section 5

PROCEDURES FOR VIDEOTAPING MOTHER-CHILD INTERACTION AT 24-MONTHS IN THE 3-BOXES PARADIGM

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Chapter 23

Section 5

PROCEDURES FOR VIDEOTAPING THREE BOXES AT 24-MONTHS

I. OVERVIEW

The Three Boxes procedure during the 24-month lab visit is designed to assess the quality of mother-child interaction during a playtime. Videotaping this procedure will enable the interactions to be scored by coders who are "blind" to other information about the families. The rating scales to be used on these videotaped observations are similar to the Qualitative Rating Scales that are being used in the live ratings of the children's interactive experiences in child care. We are primarily interested in dyadic qualities and maternal affect, sensitivity, involvement, intrusiveness, and stimulation, and the child's affect, sociability, attentiveness, and activity level. It is recommended that lab staff review these scales. A basic familiarity with these qualitative scales prior to conducting the lab visit should provide some basis for on-the-spot decisions that might need to be made while videotaping the interaction.

II. GENERAL INFORMATION AND GUIDELINES

The Three Boxes procedure follows the administration of snack. Early termination of taping should occur when the mother explicitly requests it, or when the mother is resentful, angry, or hostile ABOUT THE TAPING. In these circumstances taping may be stopped earlier than 15-minutes, but a minimum of 10-minutes of taping are needed for codable data. Throughout the episode it will be the camera person's job to capture the child and mother on videotape. Technical details on taping are supplied below in a separate section.

III. MATERIALS

Toys for Three Boxes are the same ones that are used during the 15-month mother/child interaction procedure in the home (see below).

The principles underlying the selection of the three toys were that the toys should (a) be interesting to children of this age, (b) foster different types of activities, and (c) have the potential of being used differently by the children and their mothers. Mothers can attempt both age appropriate and inappropriate activities with each toy. Each toy is placed in a separate open box (dimensions approx. 17" by 9 1/2" by 12"). The box should be covered with solid colored contact paper. There should be a large, legible number drawn on the front box. As shown in Figure 1, the boxes should be placed on a table located at one side of the playroom.

BOX 1 (Red Box). Story Book. The pictures should tell a story. Snow (1989; 1990) and Vandell (1979) have used a picture book in this context and found wide variations in mothers' language about the book, in children's interest in the book, and in how mothers structure the task. (Some mothers hold their children while they "read"; others place the book on the floor and then step away; others read while facing the child a la the teacher mode). The book is also interesting because it allows us to see (a) how mothers handle the transition if the children are not interested in the book and (b) how rich the child's language environment around books might be.

A specific book has been chosen (Barnyard Tracks), and sites will order 10 copies. (Sites are instructed to order 10 copies, since the books are paperback and may not last through more than 10 to 15 presentations.) Clear contact paper should be placed over each page of the book to allow the books to be washed after each visit

BOX 2. Toddler Kitchen (Fisher Price Model number 1035, 1990, to be purchased by sites.) This toy set includes a model kitchen along with four accessories: a mixing spoon, a frying pan, and two pieces of toy "food". The pan can be put in the stove, the spoon can be hung on the side of the kitchen, and the food pieces can be put through the holes like puzzle pieces. The doors can be opened, the "burner" can be spun, and the toast can be pressed into the toaster. Present the toy in the bag with the accessories in the "oven", and return the toys to the oven for storage. This toy can be used in various ways: including manipulative play, functional play, pretend play, and naming.

BOX 3. Discovery Cottage by Fisher Price (to be purchased by sites.) This house comes with three "tubby" figures and a car. The roof can open and reveals a mirror. The figures can be inserted in the chimney and they come out the side of the house. The figures can fit inside the garage that opens and closes. Children are very interested in this toy. It has potential for pretend play and also manipulative play.

The toys will need to be washed with dish washing liquid after each use. According to pediatricians, dish washing liquid kills just about anything, including bacteria and fairly virile viruses like hepatitis.

IV. ROOM SET UP

The room should be set up as shown in Figure 1. There should be a table on which the 3 boxes are placed in order. The table should be against the side wall in reference to the camera. The table should be high enough that the child cannot reach up to the boxes. Place toys against wall on table so that they are difficult for child to reach. There should be a throw rug approximately 3 X 5 to 4 X 6, placed with longer side parallel to the one-way mirror, to mark the area where mother and child might be likely to play. There should be two office chairs and an end table with magazines so that the mother may choose to sit and read magazines while the child plays. There should be a clock on the same wall as the camera window so that if the mother wishes to keep track of how long they play with each box, she will be able to.

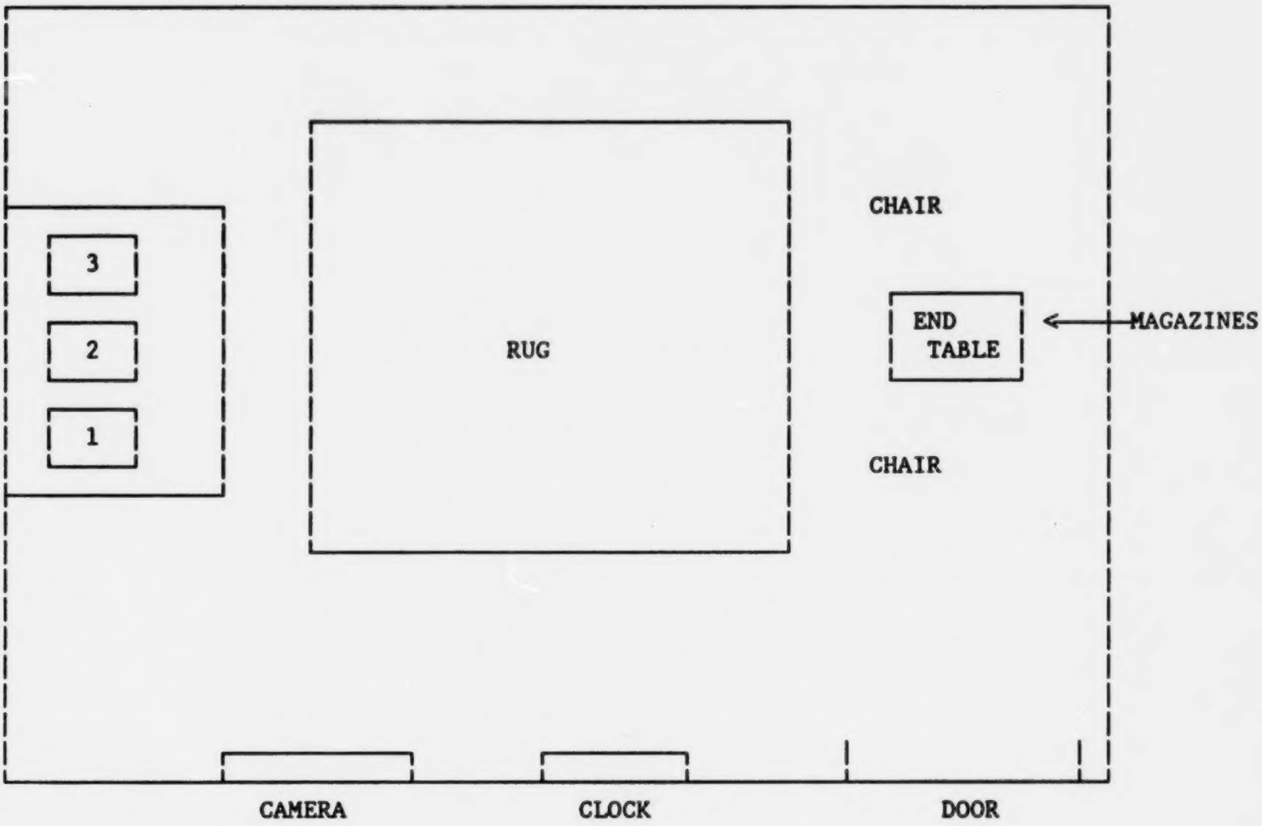
CHAIR
3
2
1
RUG
END TABLE
MAGAZINES
CHAIR
CAMERA
CLOCK
DOOR

Figure 1

V. INSTRUCTIONS

After placing the 3 boxes on the table, the visit coordinator begin the Three Boxes procedure by saying:

> "This activity will take about 15 minutes. We would like for your child to spend some time with each of the three toys in the boxes. Please have the child start with the red box and finish with the green box. During, this activity, you may play with CHILD if you would like. When 15 minutes is over, I will return to the room. You can divide the time as you like. I should remind you that we are filming (CHILD) through this glass window and will be trying to get (CHILD's) face on film as much as possible. If (CHILD) plays for a long period of time with his/her back to the window, I would like you to move him/her to a better place for our filming. Do you have any questions before we start?"

If, during the interaction, the child plays for several minutes (2+) in a position in which his/her face cannot be filmed easily, and the mother makes no moves to reposition the child, the VC should go into the lab playroom and ask the mother if she would reposition the child for better filming.

If a mother asks if she should do the red box first, the visitor should confirm,

> "We would like you to give CHILD the red box first."

If the mother asks if she can play with the child during this period, the visitor should respond,

> "That's completely up to you. Do whatever feels best to you."

Note that the visitor does not tell the mother that she has to interact with the child nor is the mother told how long the child must spend with each toy. These purposefully ambiguous instructions allow us to see (a) how sensitive mothers are to their children's interests and needs without clear instructions from the experimenter, (b) if mothers appear either uninvolved or intrusive in the face of ambiguity, and (c) how mothers handle the transition from one toy to another. We can also focus on aspects of the children's behavior as reflected in the qualitative scales (e.g., positive and negative affect; sustained attention, activity, etc.).

Once 15 minutes are up, the examiner should return to the lab room, thank the mother, collect the boxes and toys and proceed to the interview session.

VI. PROBLEM SOLVING

Any number of circumstances can arise which could potentially derail the successful implementation and completion of the videotaping of mother-child interaction. Listed below are several possible problems that might be encountered and their recommended solutions. It cannot be overemphasized that it is impossible to anticipate all potential problems. The visit coordinator should thus maintain an attitude that permits "thinking on his/her feet" in order to successfully confront challenges that might arise. Foremost to keep in mind are the needs of the mother and child and our desire to obtain high quality data.

Solutions that seriously discomfort families and breed resentment which could undermine further participation in the project must be avoided. At the same time, however, the visit coordinator must be prepared to work hard to find a solution that will enable him/her to obtain the data that is needed.

A. Video Malfunction

The videocamera should be tested prior to the initiation of taping. If the video malfunctions at the outset and cannot be fixed, a second camera should be substituted.

Do not spend an inordinate amount of time trying to fix a problem, as this could unduly lengthen the visit and/or interfere with the smooth efficient collection of the remaining data. If a problem is identified at the end of taping, determine how early it started. If more than 10 minutes of tape have been collected, there is no need to make alternative arrangements. If less than 10 minutes have been collected AND the problem can be fixed, try to get the mother to engage the child with the 3 Boxes toys so that at least 10 minutes can be recorded. If the problem cannot be fixed, apologize to the mother, let her know that you would like to reschedule at a later date, but that you will talk with her more about that once this visit is completed.

Proceed to the next phase of data collection.

B. Maternal Interruption

If the mother requests/demands to stop for any reason, approve automatically if more than 10 minutes of taping has taken place. If less than 10 minutes has gone by, let the mother know that you need only a little more time and seek her approval to continue until at least 10 minutes have been taped. If she seems resistant to, or resentful of, such a request, terminate taping and try to restart if possible when she is ready. If she does not want to do anymore, respect her wishes.

C. Maternal Refusal

If the mother says she does not want to do the videotape, remind her that other families have found it enjoyable, that parts of these tapes will be put together and given to her at the end of the study as a gift, and that no one other than research staff will view the tape. The goal here is to try to be "softly" persuasive. Empathize with her discomfort ("other mothers have felt that way"), but try to enlist her willingness. If you think that will put the mother off, go on to next phase of data collection and return to possibility of videotaping once that phase is over.

Remember, all parents have been informed that they can refuse any part of study that they want to, so persuasion has to be "soft." If a mother refuses such efforts, respect her sentiments and be sure to point out not only that it is okay, but that we promised her in the beginning when she signed informed consent that she retained the right to any and all refusal. We don't want her feeling bad about letting us down.

VII. TECHNICAL CONSIDERATIONS

A. Filming Identifying Information on the Tape

As part of the setup procedures film a sign on which you have written 1) subject number, 2) "24 Month Lab", 3) date.

This information should ideally be on an erasable board. Film the board while you read out loud the same information. Rewind the videotape and play it back, checking that the camera is operating properly.

Set the date/time clock on the camera so that this will also be recorded on the tape during the interaction. If the date/time label gets in the way of clearly viewing mother or child (especially if it covers a face), turn it off. It is better not to have the time recorded throughout than to obscure important features of the interaction.

B. What the View Finder Should Show

Keep both the mother and child in view, if at all possible. Stay close enough in (visually) to be able to see facial expressions, but not so close that you miss gestures, body position changes, etc. Children generally express affect with their entire bodies (mothers, too, but usually not as dramatically). Try to get both partners' facial expressions simultaneously; this is best achieved in silhouette positions. If, during the course of the interaction, both mother and child move such that they cannot be in the picture simultaneously, keep the child in the picture, zooming back as much as you can while still getting child's facial expressions.

Make certain that the mother and child are in focus. Use auto-focus if you can be certain that nothing will come in between the camera and the mother and child, throwing your focus onto something extraneous. If you use manual focus obtain a sharp focus by making adjustments with the zoom up close. Zoom back out to the proper distance after focusing.

Once you have the appropriate camera location, zoom distance, and focus, make further adjustments only if necessary. Tinkering with the zoom and focus over the course of the observation will make the coder's task more difficult. However, it is very possible that you will need to make adjustments. You will need to follow the child. Try to keep the mother in view as well if the child moves away. Do this by first zooming back slightly for a "bigger picture" and, if necessary, moving the camera. Both mother and child behavior must be rated on the qualitative. To make these ratings, coders must be able to observe both mother and child on the tape. The camera operator should continuously monitor the video image to make certain that the mother and child continue to be filmed properly.

C. Training

The goal in training staff to the Three Boxes procedure is to insure that the tapes document mother-child interaction in a way that enables independent scorers to rate qualities of the interaction. Picture quality and sound quality must be excellent. Training on videotape technique using examples of what constitutes acceptable and not acceptable videotapes of mother-child interaction will occur during the network training session. Each camera person should make a videotape of mother-child interaction using the 24-month protocol and send it to Margaret Tresch Owen, Timberlawn Research Foundation, P.O. Box 270789, 2750 Grove Hill Rd., Dallas, Texas, 75227, for certification that videotaping techniques are acceptable. Each person who will be participating in this procedure must send a videotape of themselves administering the procedure and/or filming the procedure.

24-Month Mother-Child Interaction Rating Scales for the Three Boxes Procedure*

I. Mother Ratings

- A. Sensitivity
- B. Intrusiveness
- C. Detachment
- D. Stimulation
- E. Positive Regard
- F. Negative Regard
- E. Flatness

II. Child Ratings

- A. Positive Mood
- B. Negative Mood
- C. Activity
- D. Sustained Attention
- E. Positive Engagement

*Adapted by the Timberlawn Research Foundation investigators and staff (M. Owen, C. Norris, M. Houssan, S. Wetzel, J. Mason, & C. Ohba) for the NICHD Study of Early Child Care Research Consortium, September, 1993.

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NICHD STUDY OF EARLY CHILD CARE
24-Month Mother-Child Interaction Rating Scales

I. Mother Ratings

Sensitivity/Responsivity

The key defining characteristic of sensitivity is that it is child-centered. The sensitive mother is tuned in to her child and manifests awareness of her child's needs, moods, interests, and capabilities. She allows this awareness to guide her behavior with her child.

In the toddler years, developmental issues center on the child's needs for autonomy and control, independence, mastery, and self-regulation. The sensitive mother is responsive to these needs and the child's own agenda. Needs for dependency on mother are present as well, and struggles between conflicting needs may be present. The sensitive mother is flexible in supporting and responding to the opposing desires that can be present simultaneously.

A sensitive mother of toddlers structures her child's physical and social environment so that the child has legitimate, interesting options for play, so the child's preferences can be honored within reason, and so that the child can remain effectively engaged in playful or goal-directed activity. The sensitive mother also offers frequent praise and encouragement, withholds criticism, and provides the right mix of support and independence so that her child can experience success, pride, and develop effective self-regulation skills.

If her child initiates social gestures verbally or nonverbally (e.g., looks at mother, asks to be held, shows mother objects, speaks to mother, touches mother affectionately); makes demands, desires or requests known; asks questions or asks for assistance, the sensitive mother responds appropriately.

If the child appears disengaged, the sensitive mother takes time to reengage her child in a manner that demonstrates awareness of and sensitivity to the child's mood and preferences for play style and content. For example, if her child is uninterested the mother may show new combinations of the toys, new activities, or other engaging opportunities; or helps the child decide what to get involved with; or helps the child make the transition to a new activity.

When her child is interested and involved with toys, the sensitive mother allows him/her to independently explore them. When the child is independently engaged the sensitive mother will still check in with her child visually and shows that she is actively taking an interest in the child's activities.

Insensitive mothers ignore their child, respond in a listless manner, or respond with developmentally inappropriate comments and behavior. Alternatively, the insensitive mother could be overstimulating and intrusive, for example in continuing in her attempts to engage her child even when the child is providing clues that s/he is seeking to end the interaction or desires to work autonomously.

The sensitive mother permits her child as much choice, control, and autonomy as possible even while enforcing necessary rules, regulations, and constraints. A sensitive interaction is well-timed and paced to the child's responses, a function of its child-centered nature. Such interactions appear to be "in sync." If the child initiates interaction with the mother or makes demands, desires, or requests known, the sensitive mother responds appropriately based on her child's behavior and speech. The mother paces activities to keep the child engaged and interested. For example, if a child doesn't want to read the book, the mother might suggest looking in the next bag and coming back to the book later. The sensitive mother allows the child to disengage when interest is lost and generally to shape the nature of the involvement. However, it is important to recognize that sensitive mothers are responsive to their child's interests in such ways that engagement and interest are typically maximized.

Sensitivity can also be inferred on the basis of how the mother manages disciplinary encounters. The sensitive mother is neither over controlling nor detached in this discipline. She responds in a way that fits the misdeed. She is aware of what motivates her child and offers explanations, when appropriate, for why the discipline is taking place and suggests more appropriate activities or interests. To be noted, however, is that excessive explanations and prohibitions that the child is incapable of understanding can reflect insensitive/intrusive caregiving rather than sensitive caregiving. Long-winded speeches and lectures often reflect the mother's lack of awareness of her child's developmental level. The insensitive mother may discipline excessively and inappropriately, such as when her child strays from her agenda. In sum, sensitive discipline is discipline that varies in accordance with the nature of the misdeed and suggests that the mother does not hold inappropriate expectations of her child.

Sensitivity to distress, anger or frustration may involve speaking sympathetically to the child, approaching the child, redirecting the child's activities, hugging, patting, picking up, or holding in lap and rocking. For toddlers, physical contact is not always the most effective or even the most appropriate response to distress. Much depends on the intensity and cause of the distress. Calm reassurance, explanations, or negotiations are appropriate responses when the distress has a clear explainable cause. When the cause of distress is unknown, the sensitive mother will try to determine the cause by asking her child. In addition to reassuring her child, the sensitive mother will attempt to alleviate the cause, where possible (e.g., help with a frustrating physical world problem). A sensitive mother also knows when a response would only exacerbate the situation and would therefore be inappropriate. While she checks in with her child, she does not "make a big deal" of the episode. Distress at this age cannot always be quickly soothed or reasoned away. A sensitive mother recognizes that in a context of calm reassurance, the distressed preschooler can learn about helping to soothe him/herself.

Markers of sensitivity include (a) acknowledging the child's affect; (b) responsiveness to the child's talk and/or activity; (c) facilitating, but not over controlling the child's play; (d) appropriate timing of activities to reflect the child's interest; (e) changing the pace when the child appears understimulated, overexcited, or tired; (f) picking up on the child's interests; (g) shared positive affect; (h) providing an appropriate level of stimulation and appropriate range and variety of activities; (i) timely discipline that matches the nature of the misdeed under consideration and the child's ability to understand and benefit from whatever reprimand is offered; and (j) general flexibility in handling compliance and autonomy issues, including not over-reacting to noncompliance and supporting autonomy while permitting dependence.

Ratings on this scale should be based on both quality and quantity of maternal behavior.

1 = Not at all characteristic. There is little evidence of maternal sensitivity. Interactions are characteristically adult-centered.

2 = Minimally characteristic. This rating should be given to mothers who display infrequent sensitivity/responsivity. While the mother is sometimes sensitive, the balance is in the direction of insensitivity.

3 = Moderately characteristic. This rating should be given to mothers who are predominantly sensitive/responsive. The mother demonstrates sensitivity in many interactions, but may show some insensitivity.

4 = Highly characteristic. This rating should be given to mothers who are very sensitive and responsive. Insensitivity is never striking. Interactions are child centered.

Intrusiveness/Over Control

Intrusive and overcontrolling interaction is adult centered rather than child centered. Prototypically, an intrusive/overcontrolling mother imposes her agenda on her child. High arousal or a rapid pace are not, by themselves, indicative of intrusive behavior--if the child responds positively with sustained interest or does not engage in defensive behavior. It should be noted that a mother can be judged as intrusive even if her child does not engage in defensive behavior (for example if the child is passively resigned to the intrusions). Intrusiveness and overcontrol are apparent when the mother does not allow her child a "turn" or an opportunity to respond at his/her pace.

Some intrusive/over-controlling mothers over-structure their child's play; they insist on their own agenda or play theme; they interrupt to redirect play; or they insist on particular uses for toys or props (e.g., "it's a bowl, not a hat;" " an oven cannot be a space shuttle"), when such control is not necessary for the child's safety. Highly intrusive mothers appear unable to relinquish control of the interaction to facilitate the child's exploration or regulation of the activity. Another example of controlling, intrusive behavior is displayed by overwhelming the child with a rapid succession of toys or suggestions, not allowing him/her time to react to one before another is presented. Extreme intrusiveness can be seen as overcontrol to a point where the child's autonomy is at stake.

Intrusive, over-control is sometimes observed during disciplinary encounters. The intrusive/overcontrolling mother appears unresponsive to the "why's and wherefore's" of a child's behavior, and instead imposes a system of rigid values and responses. Moreover, this kind of caregiving seems driven more by the mother's own moods and inflexible attitudes than by the developmental needs of her child. Thus, little distinction may be made in whether the mother is disciplining her child for engaging in truly dangerous behavior versus engaging in simply inappropriate or impolite behavior. In such instances, the mother does not modify the severity of her discipline in accordance with the seriousness of the child's behavior or the child's own sensitivity to discipline styles, and is likely to show little interest or concern for the child's feelings or goals.

Punishments by highly controlling and intrusive mothers are likely not to vary as a function of the severity of the misdeed and may reflect inappropriate expectations of what the child can to do (e.g., extended time-outs, forcing a child to stand in a corner). It should be noted, too, that another way a mother can be intrusive and overcontrolling in discipline is by over doing what would otherwise be judged appropriate mother behavior; for example, by going on endlessly explaining to a child why s/he should not do something or excessively drawing a child's attention to the consequences of his/her actions.

Specific markers characterizing intrusive/overcontrolling interactions include (a) failing to modulate adult-centered behavior, especially if the child defends against it or expresses negative affect to it; (b) offering a continuous barrage of toys, directions or suggestions; (c) not allowing the child to influence the pace or focus of play; (d) taking away toys or curtailing activities without a reasonable explanation and while the child still appears interested; (e) insisting that the child do something (play, interact) that s/he is not interested in doing; (f) not allowing the child to make choices; and (g) excessively or abruptly disciplining the child.

Mother actions that are clearly in the child's best interest, such as removing a child from danger, are not included in considerations of intrusiveness. Ratings of intrusiveness are evaluated from the perspective of the child.

1 = Not at all characteristic. This rating should be given to mothers who display no signs of intrusive or overcontrolling behavior.

2 = Minimally characteristic. This rating should be given to mothers who display minimal intrusiveness. There is some evidence of intrusiveness, but it is not typical. There are periods of interaction that are clearly adult-centered.

3 = Moderately characteristic. This rating should be given to mothers who are often intrusive/overcontrolling. Some interactions are very intrusive, or moderately intrusive/ controlling behavior is evident more often. Mothers may rarely or sporadically interact (i.e. show signs of detachment), but when they do, a substantial proportion of their interactions are inappropriate and adult-centered.

4 = Highly characteristic. The mother's interactions with her child are consistently and typically intrusive. During their play, the mother controls the interaction, allowing her child little self-direction in his/her activities. There may be a few occasions when mother is not intrusive (i.e. she may be occasionally sensitive or detached). Typically, the mother allows her child little autonomy, and essentially negates the child's experience.

Detachment/Disengagement

The detached\disengaged mother appears emotionally uninvolved and unaware of her child's needs for appropriate interaction to facilitate involvement with objects or people. This mother does not react contingently to her child's speech, play or other actions and does not provide the interpersonal support or "scaffolding" that enables the child to expand his behavioral repertoire and activities. There is little joining in with the child's play, participating in conversation, or even awareness of what the child is doing. Detached mothers do not respond to their child's attempts to interact with them or to their child's signals of frustration or difficulties in goal-directed behavior. Moreover, when mothers do interact, their behaviors are often perfunctory or intrusive and asynchronous with the child's affect and responses.

Allowing a child to play by him\herself is not necessarily a sign of detachment, this is appropriate when the child is playing happily or contentedly and the mother checks in visually with the child. This is especially true of toddlers who must be given time, space and independence to explore the object and social worlds. A detached mother appears uninterested in her child, the child's activities and the child's successes, failures, and struggles. She may also be preoccupied with her own activities (e.g., engaged in parallel play; reading a magazine, etc.).

During the toddler years, detached caregiving is often evident in the disciplinary encounters that do NOT take place or in the insufficiency of those that do occur. Detached\ undercontrolling mothers often fail to act when potentially dangerous situations arise or when the child is doing something that he\she has been told not to do (e.g., standing on the boxes; hitting the glass). It may also be the case that detached\ undercontrolling mothers fail to follow through with their stated intents (e.g., tell the child that s\he cannot have the toy if s/he continues to hit the wall with it, but then ignores the repeated behavior). Highly detached mothers fail to monitor the appropriateness of child behavior so that they can step in when some kind of discipline or adult control is called for, or, they step in only when actions are extremely unsafe or the the child's distress is severe and simply cannot be ignored. A mother's failure to monitor her child may result in too-limited, inconsistent, and\or inappropriate discipline. A highly detached mother is considered to be insensitive.

The detachment\disengagement scale contains both qualitative and quantitative components. **Markers of detachment/ disengagement include (a) rare involvement with the child in play; (b) failure to respond to the child's approaches, vocalizations, smiles or other social bids; (c) a lack of monitoring or awareness of the child's engagement in**

inappropriate behavior; (d) failure to respond to behavior and situations that call for adult regulation of child experience or whose disciplinary responses are half-hearted and inconsistent; (e) permitting long stretches of unoccupied time or wandering without directing the child to an activity; (f) ignoring the child's difficulties with the physical environment, especially where such difficulties are emotionally stressful for the child (e.g. problems handling some of the toys, such as the spoon, getting the garage door to open, etc.); (g) preoccupation with their own activities and (h) conveying any message that implies "don't bother me" or "you're unimportant."

1= Not at all characteristic. This rating should be given to mothers who display no signs of detachment or underinvolvement. When interacting with the child the mother is clearly emotionally involved, attentive and available.

2= Minimally characteristic. This rating should be given to mothers who display some detachment. The mother is somewhat disengaged, but she is more involved than not.

3= Moderately characteristic. There may be a few periods of extended detachment, or brief periods occur often. Detachment may be evident on several occasions. At these times mother shows little awareness of the child or his\her activities.

4= Highly characteristic. The mother spends little or no time attending to her child. In the rare instances of involvement, the mother's behaviors may be simple, mechanical, stereotyped, repetitive and perfunctory. However, there may be brief instances of low-level involvement. The mother is clearly not emotionally involved with the child and appears to be "just going through the motions."

Stimulation of Cognitive Development

This scale measures the degree to which the mother tries to foster her child's cognitive and mental development. A stimulating mother may take advantage of even routine activities, such as clean up, to stimulate development. She will consistently engage in a variety of explicit activities with the intent to facilitate learning, development and achievement.

Physical activities such as rough and tumble play, tickling and bouncing are not considered to stimulate development in terms of this rating. Nor do those activities that are only social (hugging or smiling) or caretaking (soothing) qualify as stimulation of development.

The focus of this scale is on the mother's effortful teaching that may ultimately enhance perceptual, cognitive, and linguistic development. If the topic or method of stimulation is poorly matched to the child's developmental level or interest, then the mother's behavior is not seen as stimulating development.

Behaviors characterizing stimulation include: (a) attempting to focus the child on an object or task; (b) focusing the child's attention on the unique attributes and perceptual qualities of objects (i.e., their colors, how they move, what they can be used for); (c) suggesting more sophisticated play activities (e.g., "why don't you try..."); (d) verbally responding to and expanding on what the child says; and (e) encouraging the child to actively participate in activities. However, mothers who simply focus or encourage should not be given the highest scores. High scores are given to mothers who (a) describe, label, or ask questions about toys or objects, or demonstrate how they work; (b) stimulate the child's language development and expand on their verbalizations; (c) read from and elaborate on text from the book; (d) encourage and reinforce the child's attempts at mastery, or challenge the child to try something new; (e) present activities in an organized sequence of steps; (f) teach the child or give him/her an opportunity to experiment with materials that illustrate or teach concepts; (g) ask questions that require problem solving; (h) label and interpret the child's experiences, (e.g. "You think that's funny"); and so on.

1 = Not at all characteristic. The mother makes almost no attempts to teach the child anything or provide any stimulation. The mother may ignore the child's activities or interact perfunctorily, providing little stimulation. Very brief, low-level stimulation may occur.

2 = Minimally characteristic. This rating should be given to mothers who provide infrequent or weak stimulation. The mother's conscious and purposeful attempts to engage in development-fostering experiences are limited. She may label or demonstrate materials, but does so perfunctorily and/or with minimal elaboration. Actions are likely to be simply repeated rather than thoughtfully varied.

3 = Moderately characteristic. This rating should be given to mothers who are characteristically stimulating, but could provide more frequent and/or higher quality stimulation. The mother may find new ways to engage the child, but these ways may be limited in number and variety.

4 = Very characteristic. This rating should be given to mothers who provide frequent, varied, high quality stimulation. They take advantage of many activities as opportunities for stimulation. Teaching or fostering development mainly characterizes the mother's interactions with the child. There may be a brief period in the interaction when lower level stimulation is evident.

Positive Regard for the Child

This scale rates the mother's positive feelings toward her child expressed during interaction with him/her. Positive regard can be demonstrated when mother displays warmth, acceptance and respect for her child.

It is evident when the mother listens, watches attentively, looks into her child's face when talking to him/her. Mothers who give praise without a warm tone as well as those who fail to praise when the opportunity presents itself, would not receive the highest score. **Markers of positive regard include: (a) speaking in a warm tone of voice; (b) hugging or other expressions of physical affection; (c) smiling; (d) laughing with the child; (e) enthusiasm about the child; (f) praising the child; and (g) clear enjoyment of the child.**

Ratings on this scale are based on both QUALITY and QUANTITY of positive regard.

1 = Not at all characteristic. This rating should be given to mothers who display no positive regard.

2 = Minimally characteristic. This rating should be given to mothers who display infrequent or weak signals of positive regard.

3 = Moderately characteristic. This rating should be given to mothers who typically display positive regard.

4 = Very characteristic. This rating should be given to mothers who are very positive, in terms of facial and vocal expressiveness and behavior.

Negative Regard for the Child

This scale rates the mother's negative regard for her child. Both frequency and intensity of negative affect toward the child are considered. Children's bids for autonomy and noncompliant behavior may elicit negative regard in the form of anger or rough handling. Disciplinary measures may or may not convey negative regard to the child. For example, if the child does something mother has asked him/her not to do, and the mother speaks with an angry, negative voice, this exchange conveys some negative regard. If, however, the mother speaks firmly to her child regarding his/her behavior this is not in and of itself negative regard.

Ratings on this scale are composed of both qualitative and quantitative evaluations. The amount and intensity of negative regard exhibited is evaluated in relation to the duration of the observation period. **Some markers of negative regard include (a) disapproval; (b) tense body; (c) negative voice when correcting; (d) criticism; (e) tense facial muscles and strained expression; (f) harshness; (g) sarcasm; (h) threatening the child; or (i) harsh punishment; and (j) roughness.**

1 = Not at all characteristic. This rating should be given to mothers who do not display negative regard for the child either in words or in expressions. No evidence of anger, distrust, frustration, impatience, disgust, general dislike, or other indicators of negative regard is observed in the mother's face or voice.

2 = Minimally characteristic. This rating should be given to mothers who display minimal negative regard. There is some evidence of low-intensity negative regard.

3 = Moderately characteristic. This rating should be given to mothers who display multiple instances of low-intensity negative regard or evidence of more intense negative regard.

4 = Highly characteristic. This rating should be given to mothers who are very negative. Feelings of negative regard are expressed strongly and repeatedly, or persistent moderate levels of negative regard are expressed. The overriding affect influencing the mother-child interaction is negative.

Flatness of Affect

This scale measures how animated the mother is with her child. Animation manifests in a broad range of facial expressions. There is variability in mother's intonation and vocal expressiveness, and hand and body movements.

The flat mother exhibits blank, impassive facial expressions and an inexpressive voice. This may reflect boredom, depression, fatigue, or disinterest. This scale assesses the mother's overall demeanor.

1 = Not at all characteristic. This rating should be given to mothers who exhibit no flatness. The mother's demeanor and behavior are consistently animated.

2 = Minimally characteristic. This rating should be given to mothers who exhibit some flatness. The mother is usually animated, but there are a few, brief occasions when flatness is observed.

3 = Moderately characteristic. This rating should be given to mothers who are mostly flat. Some periods of animation may occur, but the mother is more flat than not. High intensity flatness occurs a few times or low intensity flatness occurs for most of the observation period.

4 = Highly characteristic. This rating should be given to mothers who are predominantly flat. While there is predominant flatness, brief periods of low-intensity animation may occur.

II. Child ratings

Positive Mood

This scale assesses the extent to which the child enjoys the situation overall. Indicators of a child's positive mood include smiles, laughter, and positive tone of voice, body movements or other expressions of enthusiasm. Lack of positive affect may be manifested by a neutrality or negative mood.

Ratings on this scale should be based on quality and quantity of behavior. Ratings should reflect a balance of both the intensity of the child's positive affect and the relative amount of time positive behavior is shown.

1 = Not at all characteristic. This rating should be given to children who display no signs of positive mood. The child provides no real indication of being happy, content, or even in a pleasant state. This rating can also be used for positive expressions (laughing, smiling) that appear to be inappropriate to the situation or an inaccurate reflection of the child's feelings. The child may be expressionless or flat, or negative.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak positive affect. The child may show brief instances of positive affect, or the child may be characteristically, content or satisfied throughout the observation period, without exhibiting any strong indicators of positive mood. A rating of 2 should be given to children who are content during the observation period and who may show fleeting indicators of positive affect.

3 = Moderately characteristic. This rating should be given to children who frequently display positive affect. The child exhibits several instances of strong positive affect (expresses enthusiasm, playfulness, smiles, and laughter) and is often pleasant. A score of 3 is appropriate for the child who is consistently pleasant without exhibiting strong indicators.

4 = Highly characteristic. This rating should be given to children who are very positive, in terms of physical and vocal expressiveness. The child displays multiple instances of strong positive affect and is characteristically "pleasant" for most of the remainder of the observation period. The child shows a range of expressions and behavior that are all clearly positive. For this rating, a child can have no episodes of strong distress. When there is extensive and/or pervasive happy, enthusiastic periods, a score of 4 is called for.

Negative Mood

This scale assesses the extent to which the child cries, whines, frowns, yells, screams, tenses body while crying or otherwise expresses his\her discontentment, anger or hostility. Lack of negative affect may be manifested as either positive affect, contentment or neutral.

Ratings on this scale should be based on both qualitative and quantitative assessments.

1= Not at all characteristic. This rating should be given to children who display no negative affect. There are no signs of strong (intense crying, body stiffening) or weak (whining) negative affect from the child during the observation period. However, if a single mild fret occurs a "1" may also be scored.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak negative affect.

3 = Moderately characteristic. This rating should be given to children who display strong and\or more frequent negative affect. The child may display two or more instances of strong negative affect and/or is moderately discontented (frustrated, whining) throughout much of the observation period.

4 = Highly characteristic. This rating should be given to children who display high levels of negative affect. During the observation period the child displays several instances of strong negative affect and rarely appears to be contented. While negative affect predominates, there may be brief absences of negativity.

Activity Level

This scale assesses how motorically active the child is during the observation. The rating should take into account these aspects of motor activity: speed (moving fast, whether walking, kicking, or jumping); frequency (spending a lot of time in high energy activities); intensity (how energetic the activity); involvement (tendency to engage in high-energy games and gross motor activities over small motor activities); and a negative reaction to enforced nonactivity (reacting with restlessness, such as squirming).

1 = Not at all active. This rating should be given to children who are noticeably low key, passive, inactive, lethargic. The child stays in one place with no consistent arm or leg movements.

2 = Minimally active. This rating should be given to children who are minimally active. The child exhibits low intensity activity such as arm and leg movements, but typically stays seated in one place. The child may follow mother to retrieve a box, but does not initiate this and does not exhibit high indicators of activity.

3 = Moderately active. This rating should be given to those children who are predominantly active. High-intensity activity such as jumping, walking or running occurs several times, or the child is less intensely active for the majority of the observation period, such as squatting in front of, walking around or moving the toy, or displaying vigorous arm and leg movements, etc.

4 = Highly active. This rating should be given to the child who is very active. S/he may have brief instances of low-level inactivity, but when active, the intensity and/or frequency is very high.

Sustained Attention with Objects

This scale assesses children's sustained involvement with the world of objects. The child's attention does not jump from one thing to another quickly. The child spends more than a minimal amount of time focusing on the object s/he is in contact with. When playing with an object the child really "focuses in." Sustained attention may involve coordinating activities with several objects, such as when the child bakes a cake with the spoon, bowl and oven. The uninvolved child may appear apathetic, bored, distracted, distressed, or aimless.

The focus of this scale is primarily quantitative. Ratings are based mainly on the duration of interactions with objects, and the overall amount of time spent in these interactions.

1 = Not characteristic. This rating should be given to children who display no sustained attention to objects. The child moves from one thing to another in a nonsystematic way, without seeming to focus on what the objects have to offer.

2 = Minimally characteristic. This rating should be given to children who can sustain attention for only brief periods or for only a limited proportion of the observation period.

3 = Moderately characteristic. This rating should be given to the child who spends sustained periods of time involved in interactions with things. There are some periods of extended, focused attention.

4 = Highly characteristic. This rating should be given to the child who is clearly involved, interested, and focused most of the time. The child displays extended periods of sustained attention.

Child's Engagement with Mother (adapted from Booth, 1991)

This scale assesses the extent to which the child is socially connected to mother. Behaviors indicative of engagement include **(a) positively responding to the mother's initiation of a play activity (attending to the mother's suggestions or demonstrations of an activity and following her lead by adopting that activity into ongoing play); (b) initiating play that includes the mother (by offering/showing an object, requesting that mother join an activity, etc.); (c) positioning/orienting body toward mother; (d) sustained attention during interaction or play with mother; and (e) expressions of affection directed to mother.**

Behaviors indicative of disengagement include: (a) active rejection of mother's play overtures (by pushing offered objects away, defiance in response to mother requests, ignoring the mother); (b) engaging in self-occupied play that excludes the mother; (c) positioning/orienting the body away from the mother. Ratings on this scale should be based on both quality and quantity of behavior.

1 = Not at all characteristic. This rating should be given to children who display almost no engagement with the mother. Children given this rating seem predominantly disconnected and disengaged. They actively reject or ignore the mother's efforts to engage them and/or initiate no such efforts on their own. Isolated periods of engagement may occur, but the overriding feel of the interaction is lack of connectedness.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak engagement. These children are somewhat responsive to mother, but not in a sustained way. Brief periods of engagement may occur. Play appears self-occupied -- typically it excludes the mother although active rejection also may be present.

3 = Moderately characteristic. This rating should be given to children who are more engaged with the mother than not. The child initiates and/or responds with moderate frequency. Play frequently includes mother.

4 = Highly characteristic. This rating should be given to children who are very engaged with the mother. The child has a high frequency of initiations that include the mother and/or positive responses to the mother's initiations. Sustained play with the mother is observed.

Chapter 23

Section 6

INFORMATION REGARDING THE 24-MONTH STANDARDIZED INTERVIEW AND QUESTIONNAIRES

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Chapter 23

Section 6

INFORMATION REGARDING THE 24-MONTH STANDARDIZED INTERVIEW AND CHILD BEHAVIOR QUESTIONNAIRES

I. OVERVIEW

The administration of the Standardized Interview and Child Behavior Questionnaires at 24 months occurs in the laboratory following the parent-child Three-Boxes interaction videotaping.

The Standardized Interview and the Questionnaires are designed to collect specific information from all mothers in a systematic form using objective techniques and measures that have been used in other studies. By collecting data in this way, these data can be compared to other data from families in previous and future studies. It is important to follow all guidelines listed in this manual.

The purpose of the interview at 24 months is to collect information about any changes that may have occurred in the family since we last spoke with them at 21 months or, in some cases, since we last visited with them at 15 months. Mothers in the study were asked questions similar to these when their babies were 1, 6 and 15 months old and again, on the phone, at tri-monthly intervals. Before you interview the mother when her child is 24 months, you will need to review the family's files from these previous interviews and you will need to enter information in the appropriate places on the 24-month forms.

The Standardized Interview is made up of three sections. Section I of the Interview (Form 15A) consists of Parts 1 and 2: Part 1 asks about changes in household data, and Part 2 asks about family health and recent life events.

Section II of the Interview (Forms 15B and 24C) consists of Parts 3, 4, 5, and 6. Part 3 asks about changes in the mother's employment or educational status, Part 4 concerns the partner's employment or educational status, Part 5 asks about feelings and attitudes about employment, and Part 6 asks further questions regarding family socio-economic status. (Note that Parts 3, 4, and 5 are included on Form 15B; Part 6 of the interview is on Form 24C.)

Section III of the Interview has four components. First, we collect the Standardized Questionnaire Packet (containing the MacArthur Language Inventory, Toddler form) from the mother if she has brought it with her and answer any questions the mother may have about these questionnaires. If the lab visit precedes the home visit, the mother will not have received this packet, and she will need to be given the packet of questionnaires to complete at home and return to the lab by mail. In some circumstances, mothers may be asked to complete these questionnaires in the lab. (See Section IV.H.1., Section VI., and Appendix D for Guidelines for administering the Questionnaire packet.)

If the mother can read but has not completed the MacArthur Language Inventory for any reason, Visit Coordinators can do one of three things. They can ask the mother to complete the MacArthur after Section II of the interview (most preferred alternative), they can arrange for the mother to mail the questionnaire in along with the other questionnaires (next preferred alternative), or they can arrange to call the mother at home and complete the MacArthur and the other questionnaires over the phone. For non-reading mothers, the interviewer will administer the MacArthur verbally to the mother after Section II of the interview.

After collecting (or distributing or completing) the MacArthur Language Inventory, we explain the Ear Infection data collection procedures to the mother and ask the mother for permission to contact the child's physician or health care provider. If the mother gives her permission, we collect her signature and the appropriate information on the Physician Contact Form. Detailed information about the procedures for collecting this information from the mothers and from the medical care provider can be found in Section IV.H.2. of this chapter.

The third component of Section III is the administration of a short questionnaire regarding the mother's smoking behavior and exposure to passive smoke (Form 24Y).

Finally, we debrief the mother and update information on contact names and addresses for the family. This is done in case we need help in locating the mother in the future.

As part of this portion of the lab visit, we also administer the child behavior questionnaires to the mother. The two questionnaires to be administered are the Child Behavior Checklist (CBCL) and the Scott Adaptive Social Behavior Inventory (ASBI). The CBCL is administered between Sections 1 and 2 of the Standardized Interview. The ASBI is given between Sections 2 and 3 of the Standardized Interview. Further information regarding the administration of these questionnaires can be found in Section V. of this chapter.

To summarize, the order of administration of the interview and questionnaire portion of the lab visit is as follows:

1. Interview Section 1 (Parts 1 and 2)
2. Child Behavior Checklist (CBCL)
3. Interview Section 2 (Parts 3, 4, 5, and 6)
4. Adaptive Social Behavior Inventory (ASBI)
5. Interview Section 3
    a. Collecting (or distributing) the Standardized Questionnaire Packet. Administering the MacArthur Language Inventory (optional for reading mothers, but required for non-reading mothers, unless the mother has completed these already)
    b. Describing the ear infection data collection procedures
    c. Administering "The Year Before My Child Was Born",
    d. Debriefing and Updating Addresses

II. THE INTERVIEW AS A SOCIAL SITUATION

Interviewing is a social interaction, a form of structured conversation that calls upon everyday social skills such as tact, attentiveness, and courtesy. In a standardized interview, the interviewer has a schedule of questions to be asked of the interviewee in an organized, structured manner that is the same across all interviews. Likewise, standardized interview questions are designed to be administered to all subjects in exactly the same ways.

A successful standardized interview depends upon the interviewer's attention to two major concerns: (1) establishing an appropriate context for the interview, and (2) minimizing interviewer-related error in the data collected. In this section, we discuss some general principles as to how an Interviewer can address these concerns. Some of our comments are taken from Chapter 7, "General Instructions," of the HOME. Other comments are taken from the IHDP Phase II Assessment manual. Comments regarding specific interviewing techniques and the minimization of interviewer-related error are taken from Fowler Jr., F. and Mangione, T. (1990) Standardized Survey Interviewing: Minimizing Interviewer-Related Error. Sage Publications, Applied Social Research Methods Series, v. 18: Newbury Park, CA.

A. Establishing a Context for the Interview

This interview should be one component of a pleasant 24-month laboratory visit with the mother. It should take place in a comfortable and private place, where there is little opportunity for interruption or disruption. Mothers should feel comfortable that whatever they say will be heard only by the Interviewer (and possibly the child and the childminder) and will be totally confidential. Mothers should be made as physically comfortable as possible. The interviewer should ask the mother whether she would like to use the lavatory before the interview begins, and whether she should like to have some tea, coffee or soda or juice. The mother's chair should be a comfortable one, and attractive posters may be placed on the walls to make the interviewing room more cozy.

During the interview, the child can be engaged in play nearby. Some sites may want to take the child to another room for childminding or for Site Specific testing. Removing the child from the interviewing room can help minimize distractions for the mother. The Interviewer will need to be sensitive to the mother's need to know where her child is during the interview and to know that her child is in "safe hands". If the child is not with the mother, the mother may appreciate knowing every 20 or 30 minutes where her child is, who her child is with, and what her child is doing. Giving the mother this information regularly throughout the interviewing session may help relax the mother and make the process go quicker and more smoothly.

Before the interview begins, the interviewer will already have said several positive things about the mother's participation and about the toddler. If not, this is a good place to do so.

As much as possible, have the interview sound like a conversation. Because this is a structured interview, a conversational style is not an easy thing to achieve! The best way to achieve this is to be totally familiar with the questions and know what you're going to ask so you don't have the awkward problem of needing to "find your place." Establish a relaxed pace, and listen carefully to everything the mother has to say.

But an interview is more than just a friendly conversation. Interviewing is a professional job that requires professional skills. The tone of your voice will convey your professionalism and self-assurance. Express genuine interest in what the mother tells you. Questions should not be approached in an apologetic or embarrassed manner. These questions have been used before many times, and they have not been found to be too personal or difficult. Many mothers have told us they enjoy the interview and questionnaires, and that it helps them to think about things they had not considered before.

Show interest and positive attention to the mother. Look at the mother as she answers, nod, don't just look down for where to record the answer. Be careful, however, to avoid using terms such as "That's fine" or "Good" after the mother completes an answer. Even seemingly innocuous statements after the mother says something may subtly reinforce particular types of answers. You can, however, say, if necessary, something like, "You're answering my questions very clearly," or, "You're making my job very easy."

The quality of your interview is critical to this study. You are the key factor in determining the quality of the data we obtain!

B. Neutrality and Confidentiality

It is important that you maintain a neutral attitude toward the mother's responses. Avoid behavior that could affect how the mother answers. For example, do not suggest answers, reword or interpret the question for the mother, except according to the specific guidelines described in this manual. Do not anticipate an answer to a question.

Avoid giving your opinion, even if asked. For how to respond to questions about the study, refer to the information we give the mother about the study in the brochure, in the two-week phone call script and in the Informed Consent. Keep your answers here short and concise.

Do not let your tone or the pace at which you read the questions indicate that one answer is preferable to another. For example, do not read some response options faster or slower than others or read some with vocal inflection and others with a monotone.

A mother must feel free to speak candidly. In order for her to speak candidly, we guaranteed her (in the Informed Consent Form) that all the information that we collect about her and her family will be confidential and that all data will be kept confidentially, in a locked file cabinet. If you cannot keep confidentiality (such as in a case of child abuse), you should stop the mother and explain to her the limits of your confidentiality before you allow her to continue. Preserving confidentiality means, in addition, that you discuss data only with NICHD project staff and that you conduct interviews only with families whom you are not otherwise acquainted.

C. Informing the Mother of Her Role

One of the most critical aspects to a successful interview is "training the respondent" (Fowler and Mangione, 1990). In other words, the interviewer should let the mother know what is expected of her in this situation. This is done by direct instruction at the beginning of the interview, as well as through modeling, careful listening, and by giving the mother feedback about the appropriateness of her responses throughout the interview. Keep in mind that being a respondent is hard work. The mother must listen carefully to the questions, give complete answers, and provide them in the form required. For example, the mother must learn to fit her answers into coded response categories when her most natural answer might be "it depends."

Immediately before beginning the interview questions, tell the mother what you will be doing and what you would like from her. Also feel free during the course of the interview to "step out of the interview" to "train" the mother when necessary. Mothers are likely to feel most comfortable with the interview situation when they know what we want from them.

Positive reinforcement. When the mother responds appropriately to a question, provide positive reinforcement. This can take the form of a word or a gesture to let the mother know that this is the type of behavior you expect. Phrases such as "Yes, I see," "Thanks," "Yes, that's what I meant," are all good examples of positive feedback. You can also reinforce her behavior by nodding, smiling and writing down her comments. How much feedback you use will depend on your respondent. Some learn their role quickly and require only periodic feedback, while others may need to be reinforced every time they make an appropriate response. Be extremely careful, however, not to reinforce certain types of answers. Remember that you are reinforcing answering behavior, not content.

Digressions. There are some behaviors that you want to be especially careful not to reinforce. An interview can continue for a very long time if you allow the respondent to tell you a story while answering each question. If the mother elaborates on something when you really only need a brief answer, say something polite like, "Yes, I see what you mean. I think I've got what I need here". A long digression can be halted by saying things such as "That's interesting. Let's finish the interview and then we can talk more about this later". Such a statement not only explains why you are there (i.e., to interview her), but also communicates to her that you are interested in her as a person. Since this isn't an open-ended interview (although some questions do allow for more open-ended responses), this probably won't be a big problem, but you don't want people to feel cut off. This must be handled delicately.

Interruptions. It is important that the mother hear the entire question and all the response categories before answering. Her answer may change after she has heard all the possible answer choices. If the mother tries to answer before you have had a chance to finish reading the question, gently let her know that she needs to hear the entire question before selecting an answer. You may also want to re-read the question to her.

If the mother starts giving you answers to questions that will be asked later on, let her know that you will be asking about that topic later. You may also want to let her know that you have to ask the questions in a certain order. It is better to stop her politely than to have her go through the information twice. You must try to maintain control over the administration of the interview.

D. Pacing

Pacing is one way in which the interviewer gains control over the interview situation. Establishing a good pace does not mean reading questions in a monotonous fashion. Questions should be read at an approximate rate of two words per second. Don't pause between every word, but between word phrases.

When the pacing of questions is slow and even, mothers answer more thoughtfully, and you won't have to repeat questions as often. The mother will set the pace of the interview from information and cues provided by you. A slower and more leisurely pace will allow you to work carefully and to follow skip patterns and other interviewer instructions. Pace can also reduce tension for you and the mother. And, as mentioned earlier, slow and even pacing is important because an uneven reading of the question or response categories may bias the respondent by suggesting that some categories are more important than others.

E. Sharing Personal Information With the Mother

Even though you are trying to establish a conversational tone, you must avoid sharing personal information. By sharing such information, you may inadvertently establish certain response biases in the mother as she assesses what your values may be. The reliability and validity of the data depend upon the interviewer being able to establish an interpersonally neutral atmosphere. Making evaluative statements after the mother answers a particular question or sharing personal information with her are two major ways that an interviewer can introduce bias into the data collected.

F. When the Mother Reveals Personal Problems

Occasionally, in a mother's eagerness to talk, she makes an implied or direct appeal for help with her own personal problems. Sometimes, mothers can talk for so long about their problems that there may not be time to attend to the interview. (See earlier comments about digressions.) Interviewers should be careful about feeling that they must handle these problems or solve them for the mother. You might say something like *"I can understand your being upset (or concerned) about that. When we finish discussing the interview, we can talk about it more."*

Researchers at each site should be relatively familiar with the services that are available to parents in their area. If a situation arises in which a mother requests information or some type of referral, you may say something like, *"I can see that you would like help. I am not (trained) (in a position) to help you, but perhaps you would like me to talk with Dr.----, our Director, and s/he will know of someone that could be of help to you."* Immediately after the visit is completed, document the mother's concerns and requests on the Interviewer Report Form (see Appendix B) and discuss the situation with your Study Coordinator and/or Principle Investigator. Get back to the mother as promptly as possible with the appropriate information. If it seems appropriate to have your PI or SC speak with the mother, the Visitor should ask if the mother would like the Director to call.

Each site should keep a record of the kind of information distributed to a particular parent and what impact, if any, this had on the family's life, if known. (This can also be recorded on the Interviewer Report Form.)

III. MINIMIZING INTERVIEWER-RELATED ERROR

The proceeding section dealt with how to establish a friendly yet interpersonally neutral context for professionally conducting the interview. The following points pertain to specific interviewing techniques which minimize interviewer-related error in data collection. These include specific standardized interviewing techniques as well as standard methods for handling difficulties that may arise during interviews. It is impossible to eliminate error entirely. However, by following the techniques outlined below as closely as possible, we will greatly minimize interviewer-related error.

A. Standardized Interviewing Techniques

1. Read Questions Exactly as Written

Reading the question exactly as written is critical to maintaining standardization across interviewers at all ten sites. If the wording of questions is changed by interviewers in even the slightest way, the researchers can never be entirely sure what question the mother was answering.

There are rare occasions, however, when exceptions are allowed. Sometimes reading the question exactly as worded will compromise rapport. When this happens, the interviewer may slightly rephrase the question as a confirmatory question so long as the same words are used as in the original question. For example, based on initial piloting with the protocol, several interviewers felt silly or awkward asking the mother, "Are you breast feeding BABY?," when the mother was actually breast feeding at that moment. The Interviewer may feel free in this situation to rephrase the question in a confirmatory manner. For example, "And you are breast feeding BABY?" is perfectly acceptable in this situation.

While asking a confirmatory question may seem unnecessary in the breast feeding example, most other questions are not that clear cut. The HABIT of confirming ensures that no question is accidentally skipped.

Another occasion when a confirmatory question is allowed is when the observer already knows the answer. For example, it often occurs that the interviewer has already learned that the mother/father is self employed prior to the moment in the interview where this question is supposed to be asked. Following the guidelines above, there are two acceptable ways this situation can be handled. These are illustrated below.

Interviewer A said, "Sometimes we have a question which doesn't exactly fit the situation, but I need to ask you just for the record. Who is his employer?" She reports that so far, she has not had any mothers who seemed offended by even the most obvious questions. She feels that these types of shared awkward situations serve to build rapport, because it reminds the mother that both the interviewer and mother are engaged in a joint task.

Interviewer B, on the other hand, simply said, "And you are self employed?" Both approaches are considered acceptable. Which approach is selected depends on the interviewer's style, the mother, and the specific situation.

Interviewers will need to be as prudent as possible when deciding to use confirmatory questions because of the implication that changing questions has for increasing interviewer-related error in the data.

2. Avoid Offering Interpretations of Questions, Words, or Phrases.

Unless every interviewer were to use exactly the same alternate phrasing or definitions, offering interpretation or definitions introduces unknown variability into the procedures. However, in the interest of getting complete data and maintaining rapport, we may occasionally have to clarify a question or define a word when the mother is unfamiliar with the vocabulary. There are several situations when this may occur.

a. If a mother asks for clarification of a word or the meaning of a question and this has been defined in Sections IV or V of this chapter, you may rephrase the question using the given definition or give her the definition to help her answer the question. For example, if the mother asks, "What counts as separated?" in regard to marital status, you can tell her that it means that she is married but that she and her husband are not currently living together by choice. It is vitally important that interviewers brush up on these definitions by reviewing the information in Sections IV or V on a regular basis.

b. If the mother asks for a definition of a particular word, the interviewer may give one in certain cases even if it is not defined in Sections IV or V. If the mother simply does not know the meaning of a vocabulary word, you may offer her the definition. For example, if a mother does not know what a "tantrum" is, you can tell her that it means a fit of bad temper (dictionary definition).

An interviewer may NOT define the meaning of a word or phrase for a mother when the word is, or the phrase includes, an adjective or adverb. For example, if the mother asks how you would distinguish good or excellent health, you may not define this for her. Another example is if the mother tells you that she is usually very satisfied with her job but that occasionally she also experiences dissatisfaction and then asks, "Would that be somewhat satisfied?", you should not answer the question for her. In addition, you are not allowed to define terms like "Mostly false" or "has mixed feelings." A good rule of thumb is that if it is at all possible for mothers (and for you) to define the meaning of term differently based on differences in subjective experience, do not define the term. Instead, you may say something like the following: "In this situation we're interested in what this word means to you. Let me repeat the question...."

When you do define a word for the mother, keep your definitions short. In our experience, the more explaining you do, the less likely you are to be effective. If you choose to define a term for a mother, record the definition you used on the Questionnaire Log (if it is a questionnaire item) or on the Interviewer Report Form (if it is an interview question). If you find that you frequently have to define the same word for different mothers, try to use the same definition. In addition, share this information with other interviewers at your site so that you can all be consistent in defining terms.

3. Determine When a Response is Acceptable

As the interviewer, you will determine the acceptability of a given response. In order to make this judgment, you must understand the mother's response. You must also be familiar enough with the information in Section IV to determine whether or not the mother has answered the question sufficiently.

If the response is acceptable, record the information given and move on to the next question. A response is acceptable if it answers the question using the given response categories.

If the response is unacceptable, you must determine why. Sometimes this is because the mother answered in prose form and did not use one of the precoded response categories. Or, the mother may not have heard the entire question or may not have understood what was being asked. If you think that this is the reason behind her unacceptable answer, re-read the question, emphasizing key words that convey the meaning.

Frequently, an answer is unacceptable because it does not fit into existing response categories. In this situation, the interviewer needs more or different information from the mother and therefore, probing is required.

4. Always Probe Nondirectively

Probing means asking questions. Nondirective probing is asking questions in a way that does not prejudice the mother in any way but allows her to offer you an acceptable response.

Probing is used to re-focus the mother's attention on the available answer choices. For example, when the mother responds, "It depends" or "Somewhere between this category and this one," you need to preface your repeat of the question with a remark like, "Which comes closest..." or "In general..."

A. 4. 1. Probing closed questions. If the mother rephrases a response category, do not record the answer that you think comes the closest. Instead, ask her to select one by saying something like, "Which one of these answers comes closest to yours..." When you re-read the response categories, make sure that you read all the available choices. You do not want to narrow the choice for the mother by reading only the choices that are closest to her original statement.

A. 4. 2. Probing numerical questions. When probing for numerical responses, interviewers must take exceptional care not to lead respondents. Never ask a question that can be answered with a yes or no. Never suggest a particular range where the answer may fall. The simplest approach is to tell the mother that you need to get a specific value. If she says that she can only estimate, reassure her by stating something like, "We would like it if you would make your very best estimate. Even though it may not be exactly right, no one is in a better position than you to make this estimate. Do the best you can."

If the mother offers two numerical answers which are both possible response categories, you can simply ask her, "Which answer comes closest to how you feel/your experiences, etc.?"

A. 4. 3. Probing open-ended questions. To probe responses to open-ended questions, the following three probes may be used. "How do you mean that?" is used when the respondent provides an unclear response. "Tell me more about that" should be used when the answer is incomplete. "Anything else?" should be asked even when a seemingly appropriate answer is given to make sure that additional points the respondent wants to make are heard. If the mother simply does not answer the question, repeat the question.

A. 4. 4. Probing "I don't know" responses. "I don't know" responses need to be probed. The first job of the interviewer is to determine the origin of the respondent's problem. The answer "I don't know" can indicate several things, and sometimes the best probe is the silent probe. If the mother appears never to have thought about the issue before, you may find simply waiting expectantly for an answer produces good results! Sometimes you may need to encourage her to think about it for a second, reminding her that she is uniquely qualified to provide information on this topic. You may want to say, "I wonder if you could take a minute or two to think about it," or: "We are just interested in your opinion." If "I don't know" is given because the mother is unsure about the quality of the answer, remind her that there are no right or wrong answers to these questions and that we are interested in what she thinks.

If "I don't know" seems to reflect that the mother genuinely doesn't have an answer, it should be recorded as a "DK", and the response grid left blank. However, to be sure that this is the case, you need to probe all "don't knows" at least once. The purpose of a probe on a "don't know" answer is not to force the mother to answer if she doesn't know the answer, but to give her a chance to think about her response.

B. When the Mother Gives you Contradictory Information

If the mother gives you information which contradicts earlier answers she may have given you or information you gathered before or after the interview, you need to step out of the interview to ask the mother for clarification. For example, you might say, "I'm a little confused here. Earlier when we were discussing (fill in the blank) I recorded (blank). Am I missing something important here?" If the interview has already ended, the interviewers should feel free to bring out the interview forms and re-ask the appropriate questions. Before taking out the interview forms, the interviewer may want to first probe non-directively, (e.g. "Can you tell me more about that?") to get the "big" picture so as to be sure to cover all of the relevant questions again.

However, you may only ask the mother for clarification concerning factual information or confusing statements that she has made to you. If you think the mother's answer is inconsistent with something she has already communicated to you, you may re-read the question. However, in order not to compromise rapport or put an extra burden on the interviewer, interviewers may not re-read a question on those occasions when it might appears that the mother's answer is inconsistent with appearance (e.g. income is too little or too much given household appearance; mother says she is fine when she appears to be in considerable distress) or when the interviewer believes that the mother is, for whatever reason, not being truthful in answering the question. Such data errors will have to stand as reported by the mother.

C. When You Are Having Difficulties

Never use your own discretion in choosing answers for the mother. If the mother does not choose a category and your non-directive probing does not help, it is sometimes helpful to "re-train" the mother for her role as interviewee. Explain to her that this question has pre-determined categories and that you need her to give the answer which most accurately reflects her situation. Rapport, however, should not be compromised.

If you feel that it would be pushing the mother to repeat the question or to train her, treat her response as though it were to an open-ended question and write down verbatim what the mother has said. After the visit is completed, you will want to discuss how to code her response with other interviewers, your study coordinator and your PI.

The following is a specific example of how to re-train the mother. It is based on an actual pilot mother.

I: (Question 18, Int 2a) "How would you describe your health compared with other women your age? Would ..."

S: "Good."

I: "This is one of those questions where I have a list of responses. I'd like to read you the list so that you can choose the one that fits your situation best."

S: "O.K."

I: "How would you describe your health compared with other women your age? Would you say your health is poor, fair, good, excellent?"

S: "Excellent."

D. When Mothers Have Negative Feelings About the Interview

Not all mothers will like every question, either in interview or written form, that we ask. If a mother expresses negativity about a particular item, you should accept her opinion, but do not convey the impression that you think the question is stupid, trivial or offensive. You may want to say something like, "Some questions may not seem relevant to you or your lifestyle. Because this is a national study, we will be seeing many different types of families. For some families, this may be a relevant issue. Please answer the question as best as you can." If she seems offended by a question, supportively remind the mother that she can refuse to answer any question that she wishes to.

E. Exercises

The following exercises have been taken from the IHDP Phase II manual. Each exercise will emphasize a different type of interviewer skill. Try to answer each question listed as per the specifications of this manual. The answers follow.

Exercise 1:

Interviewer: Over the past few weeks, would you say that (child) is:

1) Not clinging, can easily be left with people (s)he knows
2) gets upset if away from you but gets over it, or
3) is very clinging; can't be left with others

Respondent: I don't know--she seems to act differently with different people. Usually, when I leave her with my mother, she's fine.

But sometimes when I leave her with the babysitter she gets really upset.

Interviewer:

Fill in response here:

Exercise 2:

Interviewer: For each statement I read, please tell me whether (child) acts this way rarely or never, sometimes, or almost always?

(Child) is worried about not getting enough.

Respondent: What do you mean by enough? Enough what? Toys, food, hugs?

Interviewer:

Fill in response here:

Exercise 3:

Interviewer: (Child) can't concentrate, can't pay attention for long.

Now in the last 6 months, is that statement very often true or often true, somewhat or sometimes true, or as far as you know, not true?

Respondent: Well normally she is pretty good about playing by herself for a long time. But in the last few days or so, she seems to get frustrated with all of her toys.

Interviewer:

Fill in response here:

Exercise 4:

Interviewer: A child's success at school depends on how much his mother taught him at home. Do you: strongly agree, agree, disagree, or strongly disagree?

Respondent: I don't know; none of my kids are in school yet, so I don't really know.

Interviewer:

List steps for probing this answer.

Answers to Interviewing Practice Exercises

Exercise 1:

The goal of this exercise is to provide practice in "probing" to get the respondent to answer with one of the existing categories. The respondent has provided an answer that boils down to "it depends". She has not answered the question. When you get an answer such as this one, re-read the question emphasizing the words that will help her arrive at an answer. In this case, begin your re-reading of the question with the phrase, "in general" and emphasize the phrase, "over the past four weeks" to indicate that she is to generalize over that period.

Exercise 2:

In this case, the respondent appears to understand the question, However, she wants clarification of a common word which can have several interpretations. You should respond "whatever 'enough' means to you".

Exercise 3:

The mother is unclear on the time frame that you want her to answer within. Stress that the information you want is what the child was usually like, or what was generally true, in the last 6 months.

Exercise 4:

There are several specific steps that you should go through before recording an answer of "I don't know". You should first use a silent probe, i.e., wait expectantly for an answer. This will give your respondent a chance to think about her answer. If she still does not answer, you may say: "I wonder if you could take a minute or two to think about it." or "We are just interested in your opinion." Then re-read the question, emphasizing key words or phrases. If the respondent is still unable to answer your question, record "don't know" by writing "DK" in the response category area, and then an "X" in the left margin to indicate that you "probed" her answer.

F. Putting it Together: A Friendly Context and a Professional Interview

It may seem that using the standardized interviewing techniques outlined above will be costly in terms of establishing rapport and a friendly tone to the visit. These techniques do not have to, and should not, interfere with our goal to provide a pleasant experience for the mother. The context in which the actual interview is embedded, i.e. what is said before, during and after the interview, is most critical in setting a relaxed and friendly atmosphere. Interviewers should also feel that they can "step out of" the interview at any time to maintain rapport. This is done by adapting to the mother's pace and the things (i.e. the child) competing for her attention. In addition, interviewers should feel free to "train" the mother whenever is appropriate by explaining to her exactly what you need from her.

While all questions should be read exactly as written, except where noted above, no two interviews will be exactly the same because the total context of the interview will be different in each case. For the purpose of minimizing interviewer-related error, all that is necessary is that the actual interview questions be read as written, with no or minimal interpretation, and that the interviewer always probes in a non-directive way and avoids all evaluative feedback. The goal for the interviewer is to become so familiar with these techniques that they become rote. In this way, attention can be devoted to listening to what the mother is saying and to responding to her concerns.

To establish and maintain rapport, it is also essential for the interviewer to be comfortable with administering the interview. If the wording of some questions seems awkward to you, practice saying these questions aloud until you feel comfortable with them.

Sometimes it is difficult because the interview itself is not perfect. It is impossible to anticipate the concerns of all of the families in our study. To some mothers, the interview will be more difficult to administer than to other mothers. At times, the interviewer may feel that the information recorded on the forms does not accurately reflect the mother's circumstances. There are many important and unique circumstances that confront some families that the interview will not tap. The interviewer's job is to help the mother provide the best information to the questions as they are given. Important information that is not included in the interview may be entered into the Interview Report Form. Also, remember that we will be updating our information every three months, so don't worry if recent changes in family circumstances as reported in the interview do not fully reflect the family's more general situation. We will find this out in later assessments.

In conclusion, the most important job of the interviewer is to establish good rapport with the mother. In those cases where the mother does not appreciate your objectives as a researcher and is not responsive to your efforts to establish rapport while maintaining standardized interviewing techniques, bend the rules as necessary to maintain rapport. (Indicate what you did on the Interviewer Report Form!) Through piloting we have discovered that most mothers are eager to cooperate with the interviewer and do their best job to be a "good" respondent.

IV. ADMINISTERING THE STANDARDIZED INTERVIEW

A. Purpose of This Section

This section provides specific information about the questions included in the interview portion of the 24-month lab visit. In addition, this section will serve as the archival description of the way in which interview data were collected.

It is vital to the success of the NICHD Study that the basic format and content of every 24-month interview be standardized. Please refer to other sections of the Operations Manual for the 24-Month Lab Visit for specific instructions regarding the way the interview is to be conducted.

This portion of the manual will be modified if necessary during training and data collection. Any suggestions for additions or amendments should be addressed to Marsha Weinraub at the Temple site and Bonnie Knoke at the Data Coordinating Center.

It is acceptable to have an Interviewers other than the Visit Coordinator administer the Interview and Questionnaires in unusual circumstances where necessary. If this will happen during the visit, be sure to inform the mother that this will occur before the Interviewer is introduced.

B. Things you may need

Things you may need for the 24-month Standardized interview include: refreshments for the mother (coffee, tea or soda or juice), toys and snacks for the child, a writing board (not a clipboard; it may wrinkle the pages), pencils (no. 2), extra interview and questionnaire forms, the operations manual for reference, response cards, an envelope in which to place the completed questionnaires, a large self-addressed stamped envelope for returning any forms to the lab, cash or check for parent, a receipt for parent signature, an audiotape recorder for reliability taping, extra audiotapes and batteries, and postcards to notify the lab as address changes occur.

C. Format of the 24-Month Interview

Every interviewer should become thoroughly familiar with the format, layout, and questions of the 24-month interview. Because of the many different family situations we expect to encounter during this study, the questions have been written to try to cover a great variety of responses. It is not possible, however, for the questions to suit every situation perfectly. At times the interviewer must adapt a question slightly so as not to appear insensitive to a mother. Whenever possible, alternate wording for these questions is provided within the text of the interview.

Within each section of the interview, there are a number of checkpoints when the interviewer must skip over particular questions or sets of questions because they are not relevant to a particular situation. It is important that the interviewer be completely at ease with these checkpoints so that the interview can proceed smoothly.

The conventions followed in this interview protocol are:

1. The directions to the interviewer that are not intended to be read to the mother are printed in ALL CAPITAL LETTERS. The questions and comments to be read to mothers are printed in upper and lower case type.
2. The interviewer is expected to continue to the next question unless instructed otherwise by a GO TO or checkpoint instruction.
3. Questions that must fit more than one situation are worded so that the choices between two wordings are in parentheses. Example: "How satisfied are you with your decision about (working/not being employed/going to school) right now?" The interviewer is expected to choose the correct wording for this particular situation, not read all options. This requires that the interviewer have the questions clearly in mind and understand the different possible situations to which

they refer, as well as being alert to the individual situation of the mother being interviewed.

4. Questions in which a person's name (or other specific information) is to be used indicate the missing information in capital letters, as, for example: "In MONTH, when we last spoke with you, you reported a problem with 1LLNESS. Is that still a problem?" The question should be read as, "In May, when we last spoke with you, you reported a problem with high blood pressure. Is that still a problem?"
5. Information in parentheses is read to all mothers UNLESS the information does not apply to that mother's situation. (For example, in Section 1, page 12, item 4. Unless the injury was an illness from a poisoning, this phrase is not read. For a second example, in Section 1, page 13, item 26: If the mother and child are the only ones in the household, do not read the phrase in parentheses "(or anyone else in your household)". For a third example, in section 1 on page 15, item 33. If the mother did not previously report a health problem, do not read the word "(other)".)

1. Marking the Forms

The mark-sense forms used for the interview must be filled in carefully. Use a #2 pencil and be sure to blacken the entire space to indicate the mother's response. Whenever there are 2 columns of numbers, as for month and day, for example, mark both columns. If your response requires only one digit, mark 0 in the first column.

For example, to record a date of February 1991:

MONTH		YEAR 199_
■	0	0
1		■
2	■	2
3		3
4		4
5		5
6		6
7		7
8		8
9		9

The blanks above the columns are for your convenience in recording mothers' responses. Often it will be quicker to simply write in the response and then fill in the mark-sense spaces later. This is especially true for complex questions that have several sets of responses, such as the household information.

In response to some questions, a mother may give you additional information that is not coded but that you want to record in order to demonstrate that what she wants to tell you is important, and also to help build rapport with the mother. You can write such information on the forms as long as you do not write over the mark-sense spaces. Be sure to keep your notes to the left side of the page.

Also, if it is not clear how to code a mother's answer, write all the relevant information on the interview, to the left of the mark-sense spaces. Before you turn in the interview, discuss the coding with your site coordinator or principal investigator.

D. Interview Script

The interview data forms contain only a few brief sentences to introduce or close sections. These were included to remind you to explain to the mother what is going to happen next. They do not have to be read exactly as they are written, but it is important to let mothers know what the general topic of your questions is going to be in advance. Interviewers can phrase these introductory and transition sentences in their own words. Once you begin the questions, however, they must be read exactly as they are written. The only exception to this rule is the occasional situation where the information requested is obvious or already known to the interviewer. In these cases, the interviewer may reword the question as a statement, confirming with the mother that the information obtained previously is accurate.

Before beginning the actual interview, it is important to give the mother some general information about the way you will be conducting the interview and what your expectations are. To explain the purpose and format of the interview, say something like:

"During this part of today's visit, I'm going to ask you some questions about your experiences as a parent so far and update our information on your family. I'll ask you some of

these questions as part of our interview while others will be asked in the form of some brief questionnaires which I will ask you to fill out. Some of the things I'll be asking you are very much like what you have been asked before. That's because we want to know how things change or stay the same over time as your child grows. Please try to answer each question by telling me how you feel right now. This part should take no more than about 45 minutes, OK?"

(If there are site-specific tasks, explain these here as well. Site specific tasks other than those the child can complete during the interview are to be administered after the weighing and measuring.) Please note that the introductory scripts printed on From 15A explain that the interview will last about one hour. For the 24 month lab visit, you should be telling mothers that this portion of the visit should last about 45 minutes.

To explain the interviewer's and mother's roles, say something like:

"In this part of our visit, I will read you a set of questions exactly as they are worded. This is so that every mother in the study is answering the same questions. I'll be asking you to answer two kinds of questions. In some cases, I'll ask you to answer in your own words. In other cases, I'll give you a list of answers and ask you to choose the one that fits best. If you have questions at any time during the interview, please be sure to ask me."

Mothers have different ways of responding to interview questions. Some are very precise and specific, but others tend to give vague responses or answer in general ways that are not codeable. You can encourage mothers to be more specific by enlisting them as partners in the process of data collection. For example, if a mother responds to the question,

"How long have you been living with (husband/partner)?"

by saying

"Since 6 or 7 months ago."

you can say,

"I can only record one answer. Would you say it's 6 or 7 months ago?"

If the actual amount of time was somewhere in between, you can explain to the mother how we round up or down to come up with a single answer. The next time the mother responds with a range of numbers instead of a single answer, follow the same procedure. Usually after two reminders, mothers will understand the requirements of the interview and begin to give you codeable responses without prompting.

E. Face Sheet/Interview Record

The front three pages of the 24-month interview form 15A are for use by the project staff at each site to help keep track of individual families. **These pages will not be sent to the Data Coordinating Unit**. The fourth page is the official record of the interview and should be included with materials sent to the Data Coordinating Unit.

In preparing for the interview, on the first face sheet, record the mother's and child's names, and the family's address and phone number. The name of the interviewer is also recorded.

On the second page of the interview forms, record the dates of previous contacts and the names of staff members who have visited with the mother. If the mother mentions someone or something that happened at a previous visit, it is helpful if you are able to identify the person who talked with the mother before.

In this interview you will only collect partner information about a live-in husband or partner. However, fill in the husband/partner or child's father's name (if known) on page 2, so that you will have this information if the topic comes up during the interview.

At the 24-month visit, you will also need to check question 23 on Form 15A from the 15-month visit. This question asks the mother whether a health professional ever told the mother that her child had special needs. If the answer was yes, you will need to enter this information in the margins of the 24-month visit, and when you get to this question at the 24-month interview, you can update this information.

After the interview, the three face sheets should be separated from the data portion of the interview form (follow the procedures set up at your site). The data will be checked and sent to the data center. The first face sheet is filed in the family's folder along with the Questionnaire Log Sheet after discussing any problems or concerns with the Site Coordinator and/or Principal Investigator for your site. The second and third face sheets (interview scripts and instructions) are thrown away.

A cover sheet is attached to the front of Sections 1 and 2 of the interview forms. These are for identification of the subject, the interviewer, and the date of the interview. Be sure these are completely filled out before sending interview data to the Data Coordinating Unit. It is wise not to fill out the date in advance of the interview, however, in case of last-minute cancellations.

If the mother is the person interviewed, code Rel code "0". If the mother does not live with the child full time, indicate this, as requested on the cover sheet of Section 1 by darkening "Not."

If the mother is not the person interviewed at 24 months, use the alternative caregiver interview forms according to the procedures described in Chapter 15.5.

If the mother requests information from an earlier interview to help in the answer of a question in this interview, say something like, "I'm sorry. We need to answer this question as best as you can at this time. The earlier information might bias your answer now, and that is the answer we need at this time."

F. Interview Section 1

Throughout this interview and manual, we refer to the reference child as CHILD, not BABY. If the mother has a new baby, be sure it is clear that we are asking about the reference child, not her new baby.

Months and dates: "Since we last talked"

Several questions request information from the mother about changes since we last talked with the mother. At the beginning of the interview, the interviewer should mention to the mother that we are updating information on changes in her family since we last talked to her on the telephone or since we last visited with her in her home. After explaining the format of the interview and the interviewer's and mother's roles (see IV.D. above), the mother should be given the exact date of the 21 month telephone contact and the 15 month home visit. This date may be repeated as part of the introductory statement before each section where update information is requested. However, during the statement of the question, only the month of the last contact should be given. The exact date of the contact should be supplied again ONLY at the mother's request.

You may say something like:

> "The questions I will be asking you today will refer back to two different time points. Some questions will refer to things that may have happened to you or your family since we spoke with you on DATE OF 21 MONTH CALL, when CHILD was 21 months old. Other questions will refer back to when we last visited you in your home on DATE OF 15 MONTH VISIT, when

CHILD was 15 months old. If this becomes at all confusing during the course of the interview, please do not hesitate to ask me for clarification."

In some cases, information from the 21 month call or the 15 month Home interview will be missing. In this case, ALL questions specifying a particular month should be asked in reference to the month of the child's 21 month or 15 month birthday, whichever is required. THIS INCLUDES updating the household chart and the Work Update chart. Because the coding of mothers' responses to these questions assumes that you have prior information from the 21 month call, you must find out what the mother's situation was when the child was 21 months old and THEN ask the questions in reference to what has happened since the child was 21 months old. We suggest that you obtain all of the necessary information to be able to ask these interview questions prior to the start of the interview. In these cases, modify the script described above using the child's 21 month and/or 15 month birthdate as the exact date back to which you will be referring.

In these situations, the data supplied will be comparable at each time point to the data we have on families that have not missed any contacts. Complete information on the mother's work situation will be collected in Section II, Part 6 of the Interview.

1. Part 1: Household Composition

Question 1

The purpose of this question is to track changes in the child's household composition and social network.

Before the interview, you will have listed in Table 1 the names and the mother's description of the relationship of all the household members reported at the 21 month phone call. Do not enter the relationship code until after confirming the information with the mother at the 24 month visit.

Read question 1 to the mother exactly as it is written, using only the proper name of household members. (Do not confirm the relationships of household members until _after_ you have entered the change codes.) If no members of the household have changed, (change code 1 for all individuals listed), confirm with the mother her description of the household members' relationship to _both_ the mother and the child. If there is a relationship change, cross out the written description, add the relationship description, and enter the appropriate new relationship codes either at the moment of the interview or shortly after. Be especially careful if the mother has married since our last interview, as this may change the child's relationship to the household members as well. If there are no changes in the relationships, be sure to fill in the previous relationship codes as listed on the 21 month phone call form. (Please note the misprint on the interview forms which refers you back to the 12 month call.) If there is no 21 month phone call form on file, go back to the most recent contact where that person is mentioned and get that relationship code. If the person is not listed on any of our forms, record their name, relationship to the mother and child, and age, sex, and relationship codes.

If an individual has moved out (change code 2), confirm with the mother the description of the household member's relationship to both mother and child at the previous phone call. Fill in the relationship codes (either now or later) from the 21 month call form, even if these have changed. If there are no 21 month call forms on file, follow similar procedures as listed in the previous paragraph.

If there is a new household member (change code 3), record all necessary information. Write in the table the person's name, the mother's description of the relationship, and complete the codes for age, sex, and relationship. If a new baby is added to the household, round the baby's age to the closest whole number. If the baby is under 6 months of age, code 00 for baby's age. If the baby is 6 months or older, code "01" (one year) for baby's age.

If someone has moved out who is not listed on a previous interview form, record their name, relationship to the mother and child, and age, sex, and relationship codes. Enter change code 2.

If the child's father or another member of the household is temporarily away from home (for example, in military service), he or she should still be coded as part of the household (change code 1). If this applies to the mother's husband/partner, complete question 2 and conduct the remainder of the interview considering the partner as living in the household.

Try to remember who lives in the household as you continue through the interview, because it will help guide whether to ask certain questions and the interpretation of some of the responses you receive.

Sometimes families move into another person's home. This would constitute a change in household composition, as the new household now includes those people living in the new location. Since every family's situation is very different, use your best judgement to differentiate temporary household changes (maybe only a week or two during renovations) which are not entered here as changes, from permanent household changes (no longer paying rent at old location, eviction), which are entered here as changes.

Question 2

If the mother told you in going through the household chart that her husband/partner was temporarily away from home and she told you the reason, code the reason under Question 2. If you are not certain, find out the reason by asking, "*And where is HUSBAND/PARTNER living now?*" Code Employment if he is on a temporary job assignment away from home or if he has a job that takes him away from home from Monday through Friday or for a week or more at a time at least once a month.

Checkpoint 1: Part-time residents and Questions 3 & 4

To make Question #3 more appropriate to the lab context, it should be modified to read, *"Do any children live in your home part of the time?"*.

Follow instructions described for full-time residents in Question #1 in order to record information on part-time residents and to confirm and record the relationship status of these residents. (Please note the misprint on the interview forms for Question 4 which directs the interviewer to fill in previous relationships codes from the 12 month visit. For change code = 2, the interviewer should fill in the relationship codes from the 21 month phone call. Again, if there was no 21 phone call form, after the interview you will need to return to the most recent records we have for the relationship code we have listed for that person.)

The children listed here are those who stay in the child's household on a regular basis -- during the summer, for example, or every other weekend. This question is not intended to record information about people, such as grandparents, who are visiting for a week or two (even if they come every year about this time), or the brother-in-law who is sleeping on the couch this week after he and his wife have separated. The grandparents are considered visitors, not members of the household, because they maintain their own residence elsewhere, but the brother-in-law should be considered to be a member of the household and recorded on the household chart in Question #1 as having moved in, if the mother believes that he will be living with them for at least a month.

For all children who come to stay in the household part of the time (every other weekend, or for 6 weeks during the summer, for example), record their first name, relationship to the child and relationship to the mother as she describes them to you. Also record their age and sex. Assign the relationship codes listed above the grid after the interview.

Checkpoint 2A: Status of Mother's Husband/Partner

From the information you collected in filling out the household chart, check off the appropriate box at Checkpoint 2, and move to the appropriate item on the interview.

Checkpoint 2B: Status of Child's Father

This checkpoint and questions 11 through 14 are **NOT ASKED** at the 24 month administration. However, if the mother volunteers information about her ex-husband or ex-partner in the course of your conversations or interview, you may ask these questions, using confirmatory question/statements as necessary. This information will be helpful in maintaining our site specific files on the family.

2. Part 2: Family Health

If there was no 21 month phone call or 15 month home visit interview, ask the mother about illnesses and injuries that have occurred since the month in which the 21 month call or 15 month visit should have been made.

One reason we may not have made a 21 month call is that the child or mother may have had a serious illness at 18, 19 or 20 months. Although you should be very sympathetic and listen well, do not record data from health problems prior to the month of the call or visit specified in the question, unless the problems continued into the month during which the call or visit should have occurred.

Question 15

Read the four choices and record mother's response. Do not try to interpret her answer for her, even if you think two runny noses are not a good reason to rate the child's health as "fair." You can add your notes about the mother's response, but you must code the answer she gives you.

Question 15 & 16

Amend to read: Since MONTH when we last spoke...

Question 17

Mother should have received a positive diagnosis of ear infection from a physician or health professional to code this as yes. Describe the medicine in her words. If she does not know the technical term for it, record what she does know (e.g., "some kind of antibiotic," "pink liquid that CHILD took for 10 days").

Question 18

If the mother has not seen a doctor to certify that her child's ears are clear of fluid, or if the child is still being treated, leave this item **BLANK**. Only answer "no" if the doctor has said the child's ears are NOT cleared of fluid. (Note: this is a change from the procedures followed at 15 months.) If the child has had more than one infection since the 21-month call, record the answer for the most recent infection that required medicine.

Question 21 and 22

When you ask the mother how many times the child has been to the doctor, she will often begin to tell you the reasons. You can move immediately to Question 22 and walk her through the responses. To slow her down, giving you time to record, you can simply repeat what she is saying and confirm it. Remember to confirm the mother's answer to Question #21 if she never states herself exactly how many times her child has been to the doctor after giving you all of the specific reasons. Your conversation might sound like this:

I: *"How many times?"*

M: *"Well, we went in early March for shots and then he got a bad cough..."*

I: *"So he had a routine check up and immunizations in March?"* (Mark Y for response 1.)

M: *"Yes, and then he got sick."*

I: *"Was this a follow-up of an earlier problem or chronic condition?"*

M: *"No, this was the first time he'd been sick."*

I: *"So you took him to the doctor for a cough. What did the doctor say was wrong?"* (Mark Y for response 3.)

M: *"He had bronchitis."*

I: *"Was Kevin hospitalized for that?"*

M: *"No, but he was sick for a week."*

I: *"Has Kevin been to the doctor for anything else?"*

M: *"No, those are the only two times."*

I: (Record 02 under Question 21.)

Repeating and confirming the information with the mother allows you to obtain accurate information in a conversational manner.

You may record more than one reason per visit if applicable. For example, a mother may take her child for a follow-up visit for an ear infection at a time that coincides with a routine examination. A mother may also take her child to the doctor for one reason, such as a routine check, and then the "reason" for the visit changes after arrival at the doctors. If this happens, code both reasons for the visit.

Response 22 (1) Routine Check-up or Immunizations refers to well-child visits or immunizations. These may be scheduled at different times by different pediatricians or clinics. We are not trying to determine which immunizations the child has received.

Question 22 (4) asks in greater detail about injuries. You can circle more than one response on 4b-4d (which you may need to do if the child has more than one injury since the [month of the] 21-month call). If the mother says "none" in response to Question 22 (4b), leave this question blank.

If an injury occurred at home with the father (mother not present), code #3, during child care (home, center, other's home).

Finally, remember to probe regarding a hospitalization for each visit unless it was for a routine examination.

Question 23

We want to identify children who are disabled or have serious illnesses or conditions that will affect their development, that is, their ability to accomplish such developmental tasks as learning to talk, read, walk, etc. Do not record illnesses or conditions that do not restrict normal activities or interfere with development, no matter how serious or "of concern" they may be. Fewer than 10% of our children will have one or more restrictive conditions.

If the mother indicated at the 15 month interview that health professionals had told her her child has special needs, then you will need to update this information. For example, you will say, "*I see that at our previous interview you indicated that you had been told that CHILD had a hearing loss (severe allergies, cerebral palsy, etc.) Is there any new information about CHILD's condition?*" If the mother did not report any special needs at 15 months, read the question exactly as it is written.

If the answer at 15 months was affirmative, but new diagnoses since that time have not confirmed the earlier diagnosis of special needs of any sort, enter "N" as the answer to question 23. If the answer at 15 months was affirmative, but the specific nature of the diagnosis has changed, enter "Y" in answer to question 23 and indicate the new diagnosis. If the answer at 15 months was affirmative, and the specific nature of the diagnosis has not changed, enter "Y" and the diagnosis from the 15 month Home Visit interview.

Sleep Problems: Questions 24-28

Read the entire question as written, including the information in parentheses if it is relevant to the mother's situation.

The intent of questions 24 through 27 is to assess child sleep disturbances as indicators of possible emotional or general psychological distress or lapses of parenting that may affect the developing parent-child relationships. The intent of question 28 is to assess how much of a problem the child's awakenings have been for the mother or other family members.

Videotaped records show that babies and young children, like adults, generally wake up several times a night. However, these awakenings are generally not noticed by other family members and the child returns to sleep uneventfully. What we want to count are those awakenings or sleep disturbances for which the child does NOT return to sleep uneventfully. We want to count their frequency and their duration.

The person in most families likely to awaken to a young child's sleep disturbances is the mother. Therefore, we are asking the mother whether the child has awakened her during the night. She may not be aware of whether the child has awakened anyone else in the household. However, sometimes someone other than herself has been awakened by the child, and these other awakenings should also be counted.

At the 6 months' administration of these questions, a mother reported that her baby cried out in his sleep, waking the mother, but the baby was still asleep! Another case (that we can imagine but that has not yet been reported to us) is one in which the baby may have awakened the husband or another family member, but not the mother. These circumstances are unusual, but you may want to be prepared for them, and the phrasings of the questions are designed to take this into consideration.

Read the information in parentheses in question 24. In question 26, only read the information in parentheses if there are people other than the mother and child in the household.

For Question #27, we are only concerned with how long the baby's sleep was disturbed, not the sleep of the mother or of anyone else in the household. For example, some children may only wake up for a minute or so, and go right back to sleep, but the mother may make herself some tea, watch TV, or read a book, sometimes for hours. For that reason, in this question, we are only concerned with how much time the child is up. However, if the mother says that the baby was not awakened, then rephrase the question as "On average, for about how long would you say CHILD was crying in this sleep?", and record the number of minutes that the baby was crying in this sleep.

If the mother says that that her child woke up more than an hour before his or her usual time for getting up and did not return to sleep, give her the following information to help her answer the question. For each episode of this type, the amount of awake time "before returning to sleep" should counted as the amount of time from when the child woke up to when he or she would usually be getting up.

For question 27, only read the information in the parentheses if the mother says that the child did not awaken but was crying in his or her sleep.

Question 28

Here we are concerned with how much of a problem the child's sleep disturbance has been for the mother or other members of the household. Some people may wake up several times a night, but they may be able to easily return to sleep, and they do not find the awakenings disturbing. Others, who may only be awakened once a week for a moment may find this very much of a problem. In still other cases, another member of the household and not the mother may be awakened, and this may also be a serious problem to the mother. Ask how much of a problem the child's sleep has been to the mother or any member of the household.

Question 29

Select breastfeeding or nursing to fit usual terminology in your region.

Be sure to update your information from the 15 month Home Visit Interview forms and not from the Six Month Home Visit Interview. The interview form is a bit confusing here.

Mother's Health: Questions 31-34

While Question 31 refers back to how the mother feels her health as been since the month of the 21-month call, the caller did not record and code the answers to the equivalent of questions 32-34. The mother may have volunteered this information, so that the interviewer may know more about her health at 21-months, but the computer (and, therefore, anyone depending on the computer to tell them) does not have a record of this. Therefore, question 32 refers back to information supplied by the mother at the fifteen month home visit.

Questions 32-34 should be read with the month of the 15 month visit or the month in which the 15 month visit would have occurred. You may "set-up" these questions by saying something like: These next questions refer back to May 10 (using exact date), when we last visited you (or, if no visit, when CHILD was 15 months old.) Remember to amend all of these questions to read, "Since MONTH, when we last spoke/visited with you...".

Question 31

Read the four choices to the mother and get her description of her overall health. Do not try to interpret her answer, even if you think differently than she does.

If mother begins talking about her health problems, move through Questions 32, 33, and 34, getting specific responses as quickly as you can without being rude. Do give the troubled mother a chance to complain or explain, but do not encourage long descriptions of health problems. Often, a sympathetic, "I'm sorry to hear that," followed immediately by the next question, will get the conversation back on track.

Do record health problems described by the mother as these may be important in her ability to (a) work and (b) provide care for her child. Also, it will help build rapport with the mother when next time she is called, you ask specific questions about her health.

Question 32

Follow up on the mother's previous description of any health problems that a reasonable person might expect to have continued. For example, do not ask about colds or flus, but do ask about backaches or diabetes. Not only will this help build your relationship with the mother, but it will provide an indication of the extent of the mother's health problems and how they may affect her ability to work.

Question 33 and 34

If mother indicates any new health problem (since [the month of] the 15 month Home Visit), get her description of the problem and record what she says. Much of this specific information is primarily useful to your site in becoming acquainted with the family and keeping track of events that may influence participation in the study.

If the existence of a health problem does not get mentioned until Question 34, you may probe further by asking, "*Would you consider _____ to be a health problem you have developed since MONTH?*". If the answer is yes, then record this information and Yes under Question 33.

If you know about a health problem before you get to Question 34, simply ask, "*Have you seen a doctor or other medical professional since MONTH?*"

Mothers' responses to Question 34 are difficult to code when they say something like, "Yes, I was at the doctor for my routine check-up." The mother is saying yes but it is clear from her specified reason that she may not have understood or heard the intent of the question which concerns seeing the doctor for any illnesses or conditions. If the mother answers this question affirmatively and then tells you that the reason for the visit was a routine check-up or exam, you must probe this answer further. Ask the mother, *"Were any of these visits for an illness or condition?"*. If the mother says "yes", ask her to specify the other reasons and code "Y" . If the mother says "No", code "N".

Pregnancy is counted as an "illness or condition".

Question 35

Ask this question only about a live-in husband/partner.

As with the earlier general health questions, read all the responses and record the mother's choice. Do not interpret her response.

Question 36 through 40

The purpose of these questions is to identify any important events impinging on the mother or the family and give the mother a chance to talk about important events that are not covered elsewhere in the interview.

Remember to ask "Anything else?" after the mother reports problems of any kind. It may be that with the report of one problem, she forgets to mention other, more or equally serious problems. As with all open-ended questions, you should keep probing until the mother has no more information relevant to the question to give you.

When mothers report any of these events, interviewers should not make any comment in response unless the mother herself shows distress or sadness. For example, death of a very ill or very unloved relative could be a positive event when viewed through the mother's eyes. Only when the mother expresses clear sadness or grief may interviewers express sympathy. The interviewer should limit any statement to a sentence and then move on (with a reasonable pause as necessary) to the next item.

Interviewers are also cautioned against responding positively to what appear to be positive events reported by the mothers. We do not want to appear to be encouraging mothers to be reporting positive events to us. Rather, all events, positive and neutral and negative, should be responded to neutrally by the interviewer unless the mother expresses distress.

Question 37

Do not read the information in parentheses, but do mark a "yes" answer here if the mother mentions alcoholism or addictions. If you ask this question and the mother answers "No" after she has told you earlier that a relative or close friend has alcoholism or addiction problems, you may ask about this situation using confirmation. You may re-enter the data as necessary.

Question 40

In this question, we only ask about the mother's moves. A move is a change in location of household. A new apartment even at the same address is a "move."

G. Interview Section 2

1. Part 3: Mother's Employment and School

NOTE: Throughout this section, a mother is considered now working for pay if she is currently going to work at a paid job. This job may take place in her own home. Mothers who are on leave or doing volunteer work or working in exchange for services are not considered, for our purposes, to be now working for pay. Record job information even if the mother works only a few hours a week.

Remember, mothers who are still on maternity leave are considered, for purposes of this interview, to be "not working for pay". Sometimes a mother who is on leave from her job performs activities related to her job for which she receives no additional pay above and beyond the compensation during her leave. According to our definition, this mother, too, is not working for pay.

Question 1, 2, and 3

The Work Update Chart allows you to record a lot of information in a small amount of space. Before going on the visit, you will fill out the Work Update Section for Primary and Secondary Jobs if the mother was working for pay at the 21 month contact (or the child's 21 month birthdate). You will include her position title and employer. A change code must be entered for each job recorded. For mothers who were not working for pay at the previous contact, these sections are left blank prior to the visit.

Question 1

For mothers who were not working for pay at the 21 month contact (or child's 21 month birthdate), begin with Question 1. If the mother has begun a new job; that is, she is currently at a job which she began after the 21 month phone call, fill in this information in the Work Update under Primary and Secondary Job Info. using "NEW JOB INSTRUCTIONS" below. [Do not record any job information for jobs she may have both started and ended between the 21 month call and 24 month interview.] You will record information for no more than two new jobs. If the mother works for pay at two jobs, you need to determine which job is primary and which job is secondary. The primary job is the one the mother works at for the most hours at the previous contact. If the mother has two jobs and works the same number of hours at each, the primary job is the one with the higher salary.

On the basis of the 21 month call, you will not know if a mother was not employed at all or if she was on leave at 21 months. You will only know that she "was not working for pay". If you know that the mother was on official leave at our last contact, sensitively remind her that our definition of not working for pay may be a bit different from hers and that some questions may seem a bit awkward. Be especially sensitive as you will need to ask the mother all of the information about her "new" job even though she may just simply be returning to a job for which she has already given us information at a previous contact.

NEW JOB INSTRUCTIONS. To complete the work update for a new job(s), you will ask the following prompts. "What is your position title?" If the job title is not clear to you, ask "What are your most important activities or duties?" and record what the mother says. Then ask, "What kind of (business/organization) is that?" and record the type of product manufactured, the primary activity of the organization, or the nature of the business.

Use the occupation coding definitions to choose an occupation category. Get as much information from the mother as you need to accurately code her occupation. For example, if you have learned that the mother works as a nurse, you need to find out if she is an RN (coded under Professional) or an LPN (coded under Technicians). Self-employed mothers frequently have an occupation that could fit under two coding categories. For example, they do administrative work to run their business (e.g. taking care of the books) and also participate in the activity of that business (e.g. clean houses if they own a cleaning contracting business). If the mother is both an administrator in her own business and also participates in the activity of the business, code the occupational category according to her "hands-on" activity. If the mother is a full-time administrator, code her occupation as an administrator. If you have questions about the proper code, talk to your site coordinator or principal investigator. The occupational coding categories can be found in Chapter 7, Appendix A.

Then ask, *"When did you start working at this job?"* To get income information, ask, *"From either annual or monthly categories choose the one that best (represents/represented) how much you (earn/earned)." Add, "Is this before or after taxes?" and hours "How many hours a week (are/were) you working for pay?"*

Question 2

If a mother was working at our previous contact, begin with Question 2 and update the information on jobs you listed under "Primary and Secondary Job Information." Update for the primary job first and then ask about the secondary job.

--- For any job in which there was no change (code=1), update the income information by asking, *"From either the annual* *or monthly categories, choose the one that best (represents/represented) how much you (earn/earned)."* Add, *"Is this before or after taxes?"* and "How many hours a week (are/were) you working for pay?"

--- If the mother has stopped working for pay at this job permanently, fill in Change Code 3, and ask, *"When did you stop this job?"*

--- If a mother says that she is temporarily away from her job on some type of leave other than being on vacation (e.g. before or after the birth of another baby, long-term disability, leave of absence, a sabbatical, etc.), confirm with the mother that she is currently not working any number of hours for pay either inside or outside of the home. If the mother is working any hours for pay (that is, above and beyond any leave salary benefits), we consider her still employed. For purposes of our study, the most important characteristic that defines a mother as being on leave, is that she and her employer have agreed upon a specific day on which she will return to work. If the mother's leave time arrangements are more informal, enter change code 3 (for job stopped) and follow the appropriate skip patterns. Remember to sensitively remind the mother that our definition of not working may be a bit different from hers and that some questions may seem a bit awkward (e.g. Why did you stop working at this job?).

If the mother fits our definition for being on leave, fill in change code 6 and ask, "When did you go on leave from your job?". Record this date under "Ending Date". Throughout the rest of employment update section, this mother is considered not working.

--- If a mother is on a regular, paid or unpaid vacation of 1 month or less, we treat her as still currently employed. In the Maternal Employment Update, we enter change code 1 and record her usual number of hour employed/week since our last contact. We also record her salary as she gives it to us. For the rest of the employment questions, she is considered employed. NOTE: We only consider the mother as being on official vacation time if she and her employer have an agreed upon date for her return. If she is just more informally taking time off from her job, count the mother as having stopped her employment (change code 3).

If the mother is on a paid or unpaid vacation for longer than 1 month but will resume employment before our next contact with her (phone or visit), we enter a change code 1, record "00" for number of hour employed per week, and record her income. The rest of the questions pertaining to her employment can be asked in reference to when she is not on vacation.

If the mother says she is on vacation for a period extending beyond our next contact with her and/or if there is question about whether she will return to her job after an extended vacation, treat the mother as having ended her job (change code 3). Follow the skip pattern appropriate to her having ended her job but be sensitive to the fact that she might still consider herself an employed mother.

--- If the mother has experienced a change in her job title or position, but her employer has not changed, fill in change code 2. Update the mother's new information by asking *"What is your position title?"* If the job title is not clear, then ask *"What are your most important activities or duties?"* and record what the mother says. Now choose a new occupation coding category from Chapter 7, Appendix A. Get as much information from the mother as you need to accurately code her new occupation rating. For example, if the mother works as a nurse, you need to find out if she is an RN (Coded under Professional) or an LPN (coded under Technicians). Self-employed mothers frequently have an occupation that could fit under two coding categories. For example, they do administrative work to run their business (e.g. taking care of the books) and also participate in the activity of that business (e.g. clean houses if they own a cleaning contracting business). If the mother is both an administrator in her own business and also participates in the activity of the business, code the occupational category according to her "hands-on" activity. If the mother is a full-time administrator, code her occupation as an administrator. If you have questions about the proper code, ask your SC or PI.

Next, ask the mother, *"When did you start this job?"* Record the date she started her new position. Finally, update her income by asking, *"From either the annual or monthly categories, choose the one that best (represents/represented) how much you* *(earn/earned." Add, "Is this before or after taxes?" and "How many hours a week (are/were) you working for pay?"*

If the mother gives both the before and after tax salaries, enter the "after" tax salary. If the mother reports both her yearly and monthly income, and they conflict, ask her to choose one. If she can't choose, record both and send a data edit form to the DCC explaining the situation.

Be sure to mark an appropriate code for Job 2. The NA code under Job 2 indicates that there is only one job being recorded.

Question 3

If the mother has begun a new job since the previous contact, record this information on the Work Update under the "New Job Information", following the instructions above called "NEW JOB INSTRUCTIONS" to complete the Work Update grid. Do not get information on jobs that the mother both started and ended between the 21 month call (or, if there was no 21 month call, from the date the child was 21 months old) and the 24 month interview.

In unusual cases, the mother may be currently working at three (or more) jobs, but there is only space to enter information from two jobs. Since we care most about the total number of hours that the mother works and her income, we will be combining information from all secondary jobs in the Secondary Job information. Report the occupation code for the job with the higher occupation code. Enter the total salary and total hours per week from all the secondary jobs. For all subsequent questions about the mother's employment, the mother may respond for all jobs combined.

If the mother works every other week, or some non weekly schedule, average the number of hours worked per week over a one month period to get an estimate of "hours per week".

Question 4

Interviewers may want to "re-set" the stage before asking question 4 on page 6 of the interview.

Count only hours at home for which she is paid, and, if she is a salaried professional, hours that are directly related to her paid employment. If the number of hours varies, ask for the "most typical situation" in the mother's opinion. The answer should be reported and recorded in terms of hours per week.

Question 5

If mother's work falls within one of the time periods listed in Question 5, record that period even if she does not work the whole time. For example, if she works from 1 to 5 p.m., record (1) Daytime. If she regularly works hours that overlap the intervals listed, record both times. For example, if she works a 12-hour nursing shift from 11 a.m. to 11 p.m., record both (1) Daytime and (2) Evenings.

Similarly, if a mother works days and evenings on a regular basis because of having two jobs, record both. If a mother's hours change from day to day on a regular basis (for example, she works 1-5 p.m. on Mondays, Wednesdays and Fridays, and 1-9 p.m. on Tuesdays and Thursdays) record both (1) Daytime and

(2) Evenings. Category (4) Times Vary should be used only when the mother's hours are different from week to week: mother works days one week and evenings the next.

As always, read the question as written. Do NOT read the response options given.

Questions 4, 5, 6 and 7 refer to all the mother's jobs combined.

Question 6

The intent of this question is to get at mothers who have to be away from home for at least 24 hours. Mothers who regularly work a night shift are not considered to be away from home overnight in connection with their job.

Question 8

Hand Card 8 to mother and ask her to choose the most important reason. Record Other only if none of the choices fit her situation. (Note: Card 8 has been modified to list reason 9 as New baby, reason 10 as other.)

Mother's health includes her mental health. For example, if mother says she experienced emotional tension or exhaustion, code 4, mother's health. Note that you do not have to ask the mother is she considers "emotional tension" to be a "mother's health" reason; the study is defining it that way.

Child's health includes behavioral reactions of the child in child care, such as the mother's belief that the child was having stomach distress, sleep problems, or eating problems.

Childcare problems are the "external" problems of finding appropriate and affordable child care. They may include lack of available care, losing a care provider, care that is too expensive or inconvenient, care that is unreliable or of poor quality, distrust of sitters, and the like.

Work-family demands in conflict includes employer inflexibility about the mother's need to take time off for family or personal reasons, or the mother's own feelings of not being able to cope with competing demands.

If the mother says something like she just changed her mind, or she thought she would be able to handle working and caring for her child but found out she couldn't, ask her to choose which of the listed reasons was the most important in her decision.

Question 10

"Going to school" is defined as enrolled in an educational program that normally leads to a degree, certificate, diploma, or the attainment of job-related skills. Correspondence courses may count here. Taking an evening course just for the fun of it does not count as going to school, nor does taking a parenting class offered by the local hospital. On the other hand, if the mother is taking an evening course on computers because she is planning to start a word processing business at home, then it should be recorded. Similarly, if the mother is enrolled in something like 6 credit hours at the local community college she should be counted as attending school even if she is not officially in a degree program.

Knowing what kind of school the mother is or was attending is important for later questions and also for building and maintaining rapport with the mother. Although this information will not be coded into the database, it will be important for you to know in future conversations with the mother.

Question 13

The intent of this question is to find out how much time the mother spends doing school work -- time in class plus time spent on school-related work. As a general rule, use the following coding rules for counting hours in school. For high school or vocational school where people enter a building and attend classes for a portion of each day, count the number of actual school hours (e.g., 8:30 to 3:30 for five days a week would count as 35 hours). For community college, college, or graduate school, count the number of credit hours in which people are enrolled multiplied by 3 to get an index of involvement with school (e.g., a student enrolled in 12 hours -- which is considered a full-time load -- would be recorded as going to school for 36 hours; a student enrolled for one course of 3 hours credit would be recorded as going to school for 9 hours). Although different types of schools will vary somewhat in their time requirements, these calculations will provide a general index of time spent.

Question 14

If mother's school hours fall within one of the time periods listed in Question 13, record that period even if she does not go to school the whole time. For example, if she attends school from 1 to 5 p.m., record both (1) Daytime. If she regularly attends school during hours that overlap the intervals listed, record both times. For example, if she is in school from noon to 7 p.m., record both (1) Daytime and (2) Evening. If the mother is in school during both daytime and evening hours regularly during the same week but on different days, record both (1) Daytime and (2) Evening. Use (4) Times vary only for situations where the mother goes to school days one week (for one month) and evenings another.

Question 16

Hand Card 9 to mother and ask her to choose the most important reason. Record Other only if none of the choices fit her situation. (Note: card 9 has been modified to list reason 9 as school on break, reason 10 as new baby, and reason 11 as other.)

2. Part 4: Husband-Partner Employment and School

We are limiting the information we gather on husband/partner employment and school to that which we consider most important to our research questions: whether he is employed or in school, how much he earns, and how many hours he spends at work or in school.

In this section, we are collecting information about the husband's/ partner's current job situation, as of the day of the interview. We update this information every 3 months during the course of the study.

3. Part 5: Feelings and Attitudes about Employment

Questions 23 and 24

Give the mother card (3) while you read the question. Choose the wording (working, not being employed, or going to school) that fits the mother's situation. If the mother works any number of hours, read the question using the "working" option. (If the mother is on leave, you may ask how satisfied she is with the decision to be "on leave" right now.)

Question 25

Give card (4) to mother and ask her to choose the one that reflects how she feels right now. Do not fill in more than one response. If the mother gives you more than one, ask her which one would be "most ideal" for her right now.

4. Part 6: Updating Our Files

Additional questions have been added to the standardized Interview. These questions were not printed on the forms that are being used to collect the 24 month data. Thus, you will use an additional form to collect the answers to these questions (Form 24C).

The last question in the Interview Section 2 (page 10) is "If you could have your ideal situation, what would it be right now? Proceed from this question directly to the additional questions on Form 24C. Information concerning these questions is printed directly on the forms provided.

Question 3.

If the husband's job title is not clear, then ask *"What are his most important activities or duties?"* and record what the mother says. Now choose a new occupation coding category from Chapter 7, Appendix A. Get as much information from the mother as you need to accurately code the husband/partner's occupation rating. For example, if the father works as a nurse, you need to find out if he is an RN (Coded under Professional) or an LPN (coded under Technicians). Self-employed fathers frequently have an occupation that could fit under two coding categories. For example, does he do administrative work to run the business (e.g. taking care of the books) and also participate in the activity of that business (e.g. clean houses if he owns a cleaning contracting business). If the father is both an administrator in his own business and also participates in the activity of the business, code the occupational category according to his "hands-on" activity. If the father is a full-time administrator, code his occupation as an administrator. If you have questions about the proper code, ask your SC or PI.

Questions 5 and 6

Speaking a language other than English requires fluent usage in the presence of the child; it is more than just a few phrases used at random intervals.

Do read the definition for "caregiver" to the mother, given with the question. For the purposes of this question, a caregiver constitutes anyone not in the child's immediate household who cares for the child 10 or more hours per week.

This person may or may not be someone we observe in child care, and they may not even fit the study definition of "observable" care".

Questions 8 through 10

The purpose of these questions is to update the employment information for mothers who have missed one or more interviews or phone calls in the months immediately preceding the 24 month assessment point. Here we obtain information about primary and secondary jobs lasting one month or more during the period from the last contact preceding this visit until the child's 21 month birthday. You may need to use additional Work Update grids to record all relevant jobs during this period.

For mothers who were previously employed, prior to the start of the interview you will have completed the first page of these Work Update grids with the most recent job information we have from the mother.

Throughout this section, use the definitions of "working", "not working", and "on leave" as given for the Work Update questions in Part 3 of the Standardized Interview. Also, follow the instructions for using change codes from that section.

Because you will encounter uncommon circumstances in trying to update employment over a span of more than 3 months, additional instructions regarding how to record this information onto the Work Update grids are included on Part 6 of the Interview Forms.

H. Interview Section 3

In this section of the interview, we ask about any items from the questionnaire packet that were left blank or that the mother may have questions about (or we distribute the questionnaire packet). We may or may not administer the MacArthur Language Inventory, we ask for permission to contact the child's medical providers about the child's ear infections, we administer the form "The Year Before My Child Was Born", we debrief the mother, and we update addresses.

1. Collecting the MacArthur and Checking Questionnaires

(The information to follow assumes, for the most part, that the home visit preceded the lab visit. However, the world does not always function as we would hope, for whatever reason, and sometimes the lab visit will precede the home visit. For guidelines to follow in these situations, see Appendix D attached to this chapter.)

Before the interview began, soon after the mother arrived at the laboratory, the mother will have been asked for the questionnaires left at the 24 month home visit. If the home visit preceded the lab visit, the mother should have completed these questionnaires prior to coming to the lab. At some point during the lab visit but before the interview began, the Visit Coordinator should have checked the forms for completeness. If there are any missing data, comments, or erroneously completed answers, the Interviewer can ask about these now.

If the mother has not completed the MacArthur Inventory for any reason, the mother should complete it at this time, if at all possible (if she and the child are not too fatigued). Always have another copy of the MacArthur Inventory in case the mother has not been able to complete it and can do it at this time. If the MacArthur cannot be administered at this time, it can be sent home with the mother and returned via mail or picked up at the home visit.

For non-reading mothers, the standardized questionnaires should also be completed, with the help of the interviewer. However, in most cases the visit may have already lasted too long, and the child should be weighed and measured and another home visit or phone call should be arranged to complete these forms.

If the mother is not able to read or is able to complete the forms independently but has not been able to do so before the visit, refer to the section on questionnaires (V) and Appendix D in this chapter for administration guidelines.

2. Ear Infection Data Collection Procedures

a. Background information

Otitis media is the medical term used to refer to an inflammation in the middle ear. Children who have ear infections have fluid which may or may not continue to be present beyond the infection itself. During episodes of ear infection the presence of fluid in the middle ear may cause some depression of hearing level. Frequent episodes of otitis media with hearing loss may result in a delay in some aspects of speech and language development. Therefore, it is important to collect information about this infection history from as many children as possible.

Feagens (personal communication) claims that maternal report is an unreliable measure of ear infection and otitis media history. Regular physician checkups and audiometric testing are optimal but cost prohibitive. Thus, we have chosen an alternative means for gathering this important data. We collected ear infection data from the medical providers at 15 months, and we will be collecting this information again at 36 months. In the event that parents switch medical providers from 24 to 36 months, we will need to send forms to both the 24 month and 36 month providers. Therefore, it is essential that we collect the medical providers' names at 24 months as well as the mother's permission to contact their provider at 36 months. For any medical providers who are new as of 24 months, we will want to get the addresses and phone numbers also.

b. Script for requesting child's medical provider(s)' names

After the MacArthur Inventory, the experimenter says the following:

"You may recall at the 15 month visit we asked you for permission to contact your child's medical providers directly in order to ask about your child's history of ear infections and upper respiratory infections. Although we will not be contacting your child's medical providers at 24 months, we plan to do so at 36 months. In order to ensure that we don't miss contacting any medical providers

your child may have seen, particularly if you should happen to change CHILD's medical providers from 24 to 26 months, we would like to get the names of any medical providers your child is currently seeing as well as your permission to contact the provider at 36 months.

Again, your participation in providing us with these names for data collection at 36 months is completely voluntary. If you are willing to have us contact your child's medical provider(s) again, please take a moment to fill out this form. If you are still using the same medical provider(s) you need to fill in the names only. If you have changed provider(s) since your child's 15 month birthday, we would like the names, addresses and phone numbers of the new provider(s). Thank you."

Hand mother Form 24L-a Physician Contact Form to get the names, addresses and phone numbers of the child's medical provider(s).

c. Trouble shooting suggestions

1. What if the mother has the following reservations about your contacting her medical provider(s) for the ear infection information?

   a. Mother is concerned about having taken the child to several medical providers.
   Assure her this is a common practice.

   b. Mother is concerned about not having taken the child to a medical provider when the child had an ear infection and/or for follow up visits.
   Tell her that this common and she should not feel negligent.

c. Mother is concerned that the child has continued to have recurrent ear infections.

Assure her that recurrent ear infections are common in children.

d. After Mother gives information about the child's medical providers and is asked if there are any other providers to whom she has taken the child, she reports that there are, but they are not relevant since the child was seen there for either well baby visits or shots or emergency treatment of things unrelated to ear infection and upper respiratory infection.

You do not have to press to get the additional names and addresses.

e. Mother has moved from one section of the city to another or from one city to another since the 15 month visit.

Ask for the names of all prior providers to which the child was taken. If the providers' addresses and numbers have already been collected at 15 months it is not necessary to get them again.

2. What if the mother has agreed to allow you to contact the medical providers, but she does not know the new providers' addresses and telephone numbers and asks to mail in the form?

Suggest that you look up the phone numbers and addresses together, if possible. (It is possible that some mothers may have difficulty looking for this kind of information.) If the mother still seems reticent or it is not possible to look up the numbers during the lab visit, take the information offered and look up the numbers after the visit. Call the new medical providers for the full addresses, if necessary.

3. What if the mother asks if the medical providers gave any information at the 15 month data collection?

The interviewer should have looked up whether the child's medical providers returned the 15 month form before the 24 month visit. She should respond either "Yes," or "No, but with your permission, we will try again at 36 months."

4. What if the mother asks if she can get some feedback on what the medical provider(s) reported at 15 months?

Tell her that the medical provider(s) must be assured that the information will be kept confidential in order for them to agree to release it. Suggest that if she wants to know more about what the medical provider(s) have found, she may want to call her medical providers directly.

5. What if the mother does not have a medical provider and asks for a referral?

Sites may want to give the mother the name of a referral source from whom she can get the name of a medical provider.

6. What if the mother wants to know more about how this information is going to be used?

Suggest that if she still has questions, she can contact the Principal Investigator at your site.

d. Ear Infection Post Visit Follow-Up

The Ear Infection Physician Contact Form will be used only to keep the names of the medical providers at 24 months on record for reference at 36 months.

3. The Year Before My Child Was Born (Passive Smoking Questions): Form 24Y

The last questions to be asked relate to the mother's smoking behavior and exposure to passive smoking the year prior to the target child's birth. The following script should be used to introduce these questions:

> *And finally I would like you to answer some questions about you and your friends' smoking behavior in the year prior to CHILD's being born.*

Hand form 24Y, The Year Before My Child Was Born, on a writing board with a pencil to the mother for her to complete.

4. Debriefing

After the interview and questionnaires for this 24-month visit have been completed, give the mother a chance to tell you anything that is important to her that you haven't asked and to ask you any questions about the visit or the study.

This is necessary to give the mother a sense that she is an important part of the research process and to give her the chance to express any adverse feelings she may have had about the interview. The interviewer needs to be sensitive to any negative affect in the mother and needs to give the mother a chance to share her feelings. If the mother asks questions about the research hypotheses, try paraphrasing the information in the consent form and two-week phone call.

5. Address/Phone Number Updates

Finally, the interviewer must update addresses and phone numbers. Then check to be sure the family does not have plans to move. If there is a chance the family might move in the next few months but no definite address or phone number is available, have a card or letterhead with the project address and phone number printed on it, and ask the mother to contact your office if they do decide to move.

It is very useful to have the work addresses and phone numbers of both mother and father as possible back-up contacts. Also, be sure to ask if it is OK to call the mother or father at work.

It is vital to have the names, addresses, and telephone numbers of one or two people who will know where the family is. Sometimes you may feel you are pressing the mother a bit to get these back-up contacts. We cannot overemphasize how important it is to have at least one other person who can be called or contacted if the family suddenly disappears with an unlisted phone number or disconnected phone. Therefore, it is worth "pushing" -- politely, of course -- and perhaps explaining that this is a very important study and we want to be sure that the family has an opportunity to be included in all phases of it.

Conclude the interview portion of the visit by saying something like, *"That's all the questions I have for this visit. Thank you very much for your help."*

V. ADMINISTERING THE CHILD BEHAVIOR QUESTIONNAIRES

The Child Behavior Questionnaires are to be administered to the mothers after completing each of the first two sections of the Standardized Interview. The Child Behavior Checklist is administered after completing Section 1 of the Standardized Interview, while the Adaptive Social Behavior Inventory is administered after the completion of Section 2 of the Standardized Interview. The ASBI and CBCL should each be sent with a completed DM-I form to the DCC.

A. CHILD BEHAVIOR CHECKLIST (CBCL)

The purpose of this assessment in the laboratory at 24-months is to obtain a parental rating of children's behavioral/emotional problems. Toward this end, each mother will complete the Achenbach Child Behavior Checklist For Ages 2-3 (CBCL/2-3). Mothers rate their child on each item that describes the child currently or within the last 2 months. The CBCL/2-3 consists of 99 items describing behavioral/emotional problems, plus an open-ended item for additional problems.

The mother is given a writing board containing the CBCL and a pencil. The following directions are given to the mother:

> *"Here is a list of items that describe children. Please fill out this form to reflect how your child behaves now or has behaved in the last two months. Please answer all items as well as you can, even if some do not seem to apply to your child. Feel free to write additional comments in the space provided on page 2. Please read the instructions at the top of the form before you begin. If you have any questions, please do not hesitate to ask me."*

VI. THE ADAPTIVE SOCIAL BEHAVIOR INVENTORY (ASBI)

The purpose of this assessment in the laboratory at 24-months is to obtain a parental rating of children's adaptive social behavior. Toward this end, each mother will complete the Adaptive Social Behavior Inventory (ASBI). Mothers rate their child on each item that describes the child. The ASBI consists of 30 items describing children's adaptive social behaviors.

The mother is given a writing board containing the ASBI and a pencil. The following directions are given to the mother:

> *"Here is a list of items that describe children. Please fill out this form to reflect how your child behaves. Please read the instructions at the top of the form before you begin. If you have any questions, please do not hesitate to ask me."*

VII. ADMINISTERING THE STANDARDIZED QUESTIONNAIRES PACKET

A. General Questionnaire Scripts and Concerns

Most mothers will have been given the questionnaires at the 24 month HOME visit to be completed on the mothers' own time. (If the home visit has not been completed, the guidelines in Appendix D will need to be followed.) The Visit Coordinator will collect these questionnaires from the mother at the beginning of the lab visit, and she should check them at some time before the Interview for completeness and comments. At this point in the visit, the Interviewers should ask the mother about any missing questionnaire packet data and then answer any questions about the items in the packet the mother may have had.

For mothers who cannot complete the forms independently, these will be administered after Section II of the Interview. (Reading mothers who prefer to complete the questionnaires at the lab visit may be allowed to do them on their own without Interviewer assistance. However, for reading mothers, these questionnaires, with the possible exception of the MacArthur, should be completed after the weighing and measuring procedures. If there are any problems, the reading mothers can always mail in their packets to the lab.)

Instructions for the Non-Reading Mothers

When you reach the questionnaire section, you may say something like:

"Now I have some questionnaires for us to do together. You may remember answering some of these questions before. I want you to answer these questions about what is happening right now or how you feel about things at the present time. If you have any problems with any of the questions, please let me know".

Be sure to let mothers know that they should ask if they do not know what they are supposed to do.

Read the information at the top of each form to introduce each form to the mother. You do not have to say these sentences exactly. When the mother completes each questionnaire, say "thank you," not "that's great" or even "fine". It is common for people to worry that they are doing questionnaires "right" (more about that later), so do not use any evaluative words that make them feel that you are judging whether they did it "right" or not.

B. Encountering Unusual Circumstances

Several unusual situations have arisen in piloting. Following are some ideas for dealing with them.

1. The mother asks someone else to help with the questionnaire answers (her husband, her mother, a friend): Politely make it clear to her that we want HER best answer and that in all the families we are asking the mothers to give these answers. So to make it comparable from family to family, we need her to answer the questions without consulting with anyone.

2. The mother is concerned that she doesn't know the "right" answers! Make it clear to her that there are no right or wrong answers, and we want her opinion or best response to the questions.

3. The mother asks you what is meant by "very satisfied" or tries to tell you how she feels and wants you to say whether that is a "very satisfied" or just a "satisfied": You MUST NOT help her arrive at an answer. If she is confused about the question itself, you can try reading the question to her as it is stated using intonation to try to make it clearer. Give her time to think about it. Allow the mother to be confused, if necessary. Give her a chance to figure it out. If that truly doesn't work you can explain the meaning of a word to her if that is the problem, but she must decide on the answer. So if she says something like, "What would constitute a very satisfied" or "I feel this way, do you think that is very satisfied" or "my baby does this, would you consider that fretful", reply that she must make that judgment; we are interested in what she thinks. Please see the Operations Manual for more specific rules regarding defining words for mothers.

If words are defined for a subject, please be sure that is recorded on the Questionnaire Log (the word that was defined and how it was defined). However, note that defining words is discouraged; defining words early in the protocol will encourage mothers to ask more and more questions. We want to encourage the mothers to use their best judgment. However, in cases in which you feel the mother's response would be invalid because she does not understand the meaning of a word, you may define that word for her. Some suggested definitions are given in the following sections. Try to use those definitions.

4. The mother is filling out the questionnaire incorrectly, for example, by writing down the number of her response, instead of blackening the space: If you see that the mother is filling out the questionnaire incorrectly, stop her and tell her again what we need her to do. If the mother is marking too lightly, you may want to ask her to make her marks darker. These forms should be checked before going to the data center and responses darkened if necessary.

5. The mother expresses negative feelings about the questionnaires, a particular questionnaire, or a particular question (i.e., says the questionnaires are redundant, silly, trivial, or don't apply to her): You should be accepting of the mother's opinion, but DO NOT convey the impression that you think a questionnaire or a question is dumb, silly, or trivial. DO NOT be defensive and try to defend any specific measure or question. You may want to simply say something like, "Some questions may not be as relevant for you as for other people. Because this is a national study, we will be seeing many different types of families. For some families, this may be a relevant question. Please answer the questions as best you can". If the mother seems offended by any question, supportingly remind the mother that she can refuse to answer any question she wishes to.

6. The mother wants to change the order of the questionnaires or do some and not others: You should tell the mother that we need to do things the same way with each family that we see, so we need her to do the forms in the original order

and we want her to do all the forms. However, remind her that if there is anything that she doesn't want to answer, she doesn't have to answer it. If she insists on doing things in a different order, allow her to complete the forms her way. Indicate on the protocol that the order was changed and how.

7. The mother needs to leave and she hasn't finished all the questionnaires or she's tired and wants to stop, but says she will fill out the other forms later and mail them in: You should encourage the mother to finish, but don't push too hard, we don't want poor data. You may give her the remaining forms and a self-addressed stamped envelope (which you should always have) for her to mail back. Ask the mother to complete the forms by herself in the order they are given to her. Stress to the mother that you will need to receive the forms within a week. Call to remind her if you have not received them within four days. Pay the mother for the visit only after the receipt of all materials unless it is not her fault that the visit had to be curtailed.

B. Scripts and Problem Solving for Specific Questionnaires

The following sections list information/concerns/vocabulary words specific to each questionnaire. This information need only be used with nonreading mothers, as other mothers will be completing these questions independently.

1. Form 15D: MY FEELINGS

Note the misprinting and use the designations above the columns to solicit the mother's responses.

Below are several suggested definitions if the mother has difficulty with these words:

"effort" ... work, try
"depressed" ... low in spirits

2. Form 15E: PARENTAL CARE

If the mother says that a lot of these things have not happened yet, you should point out to her that the instructions say "as you are feeling now or think you will feel as your child grows older." So if something hasn't happened yet, they should respond according to how they think they will feel as their child grows older.

Below are several suggested definitions if the mother has difficulty with these words:

"adjust" ... get used to
"distressed" ... upset
"prefers" ... likes better or likes best
"unfamiliar" ... something you are not used to or have not seen
"soothe" ... make to feel better

3. Form 15F: RELATIONSHIPS WITH OTHER PEOPLE

Below is a suggested definition if the mother has difficulty:

"encouraged me" ... gave me confidence or support

4. Form 15G: COMBINING WORK AND FAMILY

This questionnaire is administered only to mothers who are employed 10 or more hours per week.

Below are several suggested definitions if the mother has difficulty with these words:

"rewarding aspects" ... good things
"prefer to" ... rather
"resentful" ... annoyed
"conflicting obligations" ... things you need to do at the same time
"competent" ...able to do

5. Form 15H: FAMILY FINANCES

Note that item 6 is answered only if the answer to item 5 is "yes".

Many mothers fail to note items h through k. You are not supposed to call her attention to these items, as this will invade her privacy and possibly, invalidate the standardization of the questionnaire.

7. Form 15I: PARENTING EXPERIENCES

Below are several suggested definitions if the mother has difficulty with the meaning of these words:

"unending" ... never ending
"tied down" ...feeling like you can't get out
"strain" ......difficulty
"conflicts" ...arguments, fights

"companionship" ...company

8. Form 15J: JOB EXPERIENCES

This questionnaire is administered only to mothers who are employed 10 or more hours per week.

Troublesome words have been defined in the section above (Form 7).

VIII. AFTER THE VISIT (See Section 15.1 for more complete instructions)

A. Reviewing the Data Forms

After the visit is completed, look over the entire interview form to make sure that each item was completed and coded properly. (In some cases, you may actually be able to check this information while the mother is completing questionnaires.) Before posting the data weekly to the DCC, have another interviewer review the forms to be sure they are accurately completed. There are many opportunities for oversights and a second "eagle eye" may spot them.

B. Documentation

After the lab visit, complete the Questionnaire log sheet and the Interviewer Report Form.

IX. ENCOUNTERING UNUSUAL CIRCUMSTANCES

1. If you have not completed asking the information up to the mother's employment section, you should schedule another time to visit or call the mother at her home.

2. The mother's partner is female: If the mother defines a woman as her partner, then all questions pertaining to partners in the interview should be asked with respect to this person. Substitute "she" for "he" wherever this is appropriate.

Appendix A: Training and Quality Control for the Standardized Interview

Training and Quality Control for the Standardized Interview

Your actual training program will vary depending on whether the Research Assistants for the 24-month Interview have already done the 1-, 6- or 15-month visits and are familiar with the techniques for the structured interview and questionnaires. In November 1992, Dr. Lyz Jaeger will train Lab Coordinators on the procedures for the Interview and Questionnaires at the General 24 month lab training in Pittsburgh. Information regarding how to prepare for that training will be distributed to sites in September, 1992. Until then, the following information may be helpful.

A. Training Experienced Research Assistants

All 24 month Interviewers must be re-certified for administering the 24 month Interview, whether or not they were certified at 15 months.

For experienced visitors, we would recommend the following training procedures for the standardized interview. Give each visitor a copy of this chapter and of the interview and questionnaires themselves, and ask them to review everything before meeting. When you meet, discuss any questions they may have. Then have the interviewers role-play the interview with each other, taking roles that try out various family situations (mom at home, mom working at six-months and now, mom returned to work at 21 months, single parents). You can also use this meeting to review any questions on which you think your interviewers might need extra practice.

Then, have the interviewers do just the structured interview with someone they don't know (perhaps a family you've used before for pilot-testing), but not one of the formal pilot families -- save them for the "full-dress-rehearsal" of the entire 24-month protocol. Have the interviewers tape-record these interviews, and then listen to them, using the Interviewer Monitoring Form to note any problems. Review these taped interviews with the visitors. If there are no serious problems, proceed to the full-dress-rehearsal.

B. Training New Research Assistants

New research assistants will need a complete orientation to the purpose of the structured interview. We would recommend that you follow the training guidelines for the one-month interview in training new visitors to do the structured interview, especially the role-playing and taped practice interviews. It takes several complete structured interviews before most research assistants are comfortable with the flow of this type of interview, and the guidelines for probing and confirming.

C. Quality Control

We will follow similar quality control procedures for the 24-month structured interview as were used for the 1, 6 and 15-month interviews. Two interviews will be completed and certified as reliable before official data collection begins with each interviewer. In addition, interviewers will tape their first two "live" interviews which will also be monitored. After passing these interviews, the interviewer will tape the first interview of each month. All completed Interviewer Monitoring Forms are to be sent to the DCC as soon as they are completed.

These audiotaped interviews will be scored, using the Interviewer Monitoring Form, by the Site Coordinator, or other person designated to maintain the reliability of the structured interviews. The Monitoring Forms will be reviewed with the visitor. If the visitor scores below 190, or has a score below 10 on any single category on the Form, the interviewer will need to conduct mock interviews until two consecutive interviews reach the 190/10 criterion again. The first two "live" interviews they do after this should also be audiotaped and scored using the Monitoring Form.

In addition, EVERY interview and all questionnaires will be reviewed by someone other than the visitor conducting the interview to ensure that data is recorded correctly and that answers are coded accurately. We recommend that visitors review each other's interviews; we find this alerts them to the types of errors that are easily made in this kind of a protocol.

D. Cross-Site Reliability

We will follow the procedures used for the one-month protocol. The Site Coordinator, or other person responsible for scoring the visitors' interviews on the Interviewer Monitoring Form, will receive a packet of criterion Interviewer Monitoring Forms, tapes and interviews to use to establish their reliability.

Appendix B: Specific Forms to be returned to DCC

1. Interview sections 1 (15A), 2 (15B), and Part 6 (24C)
2. Questionnaires
3. CBCL (12M) with DM-I form
4. ASBI (12J) with DM-I form
5. The Year Before My Child Was Born (24Y)

Appendix B: 2. Questionnaires

5. My Feelings (Form 15D)
6. Parental Care (Form 15E)
7. Relationships With Other People (Form 15F)
8. Family Finances (Form 15H)
9. Parenting Experiences (Form 15I)
10. Job Experiences (Form 15J)
11. My Child Care (Form 15HK
12. MacArthur Communicative Inventory (Form 15M)

Appendix C: Forms NOT returned to the DCC

1. Interviewer Monitoring Form (except for those needed for certification and reliability)
2. Questionnaire Log
3. Physician Contact Form
4. Parent Permission for Physician Contact Form

Appendix D: Guidelines for Administering the Standardized Questionnaire Packet at the 24 month Visit

The standard protocol calls for Home visitors to leave the MacArthur Language Inventory and the questionnaire packet at the home visit for the mothers to complete and bring to the lab visit. Should mothers not be able to read, the questionnaires are to be administered at the lab visit.

However, there are a number of ways in which this protocol may need to be revised: the home visit takes place AFTER the lab visit, the mother forgets to complete the questionnaires before the lab visit, the mother needs assistance with the questionnaires and this was not done at the lab visit for whatever reasons. In these circumstances (and any others we have not envisioned), please use the guidelines below.

Guidelines:

1. Always hand out questionnaire packet at the first visit, (Home or lab). In most cases, this will be the home visit. Enclose a stamped, lab addressed mailing envelope with the packet.

2. Pick up the completed questionnaire packet at the next visit.

3. The lab team is always responsible for follow-up, to be sure that they have the completed data and that they send it to the DCC.

4. At the second visit, usually the lab, but possibly the home visit, the questionnaire packets are collected. If the mother does not have her packet, she may be given a second one. However, all mothers will be paid for their visit, whether or not they return their questionnaires.

5. If there is some concern that the mother may not be able to complete the questionnaire on her own time and return them via mail, sites may choose to have the mother complete the questionnaires at the lab visit. This assumes that both the mother and lab team have the additional time required.

****

Below is a detailed list of instructions for implementing these guidelines.

1. When the lab visit precedes the home visit: Guidelines for the lab team

a. Give the mother a manila envelop with the MacArthur and common protocol questionnaires. Attach postage to the envelop and address it to the lab, so that it can be mailed back, if the mother wishes or if the packet is not picked up at the home visit, for whatever reason.

(1) Tell the mother that we would like her to complete these materials in the next few days, and that we will pick up the packet when our home team visits her in her home.

(2) Alert the home team to pick up this packet at the home visit. When the packet is returned, the lab team can consider this subject's materials completed.

(3) If the packet is not retrieved at the home visit, it is the lab team's responsibility to call the mother a reasonable number of times (at least two), within a reasonable period (3 to 5 days after the visit) to retrieve the completed material.

b. If past practice has shown difficulties with the mother returning materials by mail, and/or if the lab team is able to spend the additional time with the mother and child to complete the questionnaires (40 minutes total: MacArthur: 20 minutes, Questionnaire packet, 20 minutes), the mother may be invited to complete them during the lab visit. The MacArthur may be completed after Section II of the Interview. The rest of the questionnaires may be completed after the completion of the height and weight measurements.

Some mothers may not be able to spend the additional time; other mothers may welcome the free child care and comfortable space that we offer her to get her questionnaires done "on the spot". Having the mother complete the questionnaires at the lab visit is desirable (when possible), because then we are assured that the questionnaires are received. Mothers may not be able to complete them by the time we visit the home. Administering these materials at the lab visit, we can avoid additional postage and time-consuming follow-up calls.

(1) In these circumstances, if the lab team determines that they do not have the additional time, or if the mother cannot stay to complete both the MacArthur and the questionnaire

packet, then perhaps there is time to complete just the MacArthur Language Inventory (20 minutes). If so, do so after Section II of the Interview, and give the mother the questionnaire packet to be picked up at the home visit.

c. If the mother needs help in completing the questionnaires, (i.e., she cannot read), the lab team should prepare to administer the MacArthur and questionnaires at the lab visit after Section II of the Interview. Additional time will need to be scheduled, and the mother should expect to stay at the lab visit for at least three hours to complete the Common Protocol.

(1) If there is any problem administering the questionnaires, they can be administered over the phone, on a separate lab visit, or if necessary, after the 24 month home visit.

e. In any case, pay the mother for the lab visit.

2. When the lab visit precedes the home visit: Guidelines for the home team:

a. If the lab visit takes place before the home visit, the home team should be on alert. They will need to find out from the scheduler or from the lab team whether they are to retrieve or administer questionnaires at the home visit. If so:

(1) At the confirmation call, the caller should ask the mother to please have the questionnaires completed and ready for pickup at the home visit. If the mother has not completed them

yet, the caller should ask the mother to see if she could try to find time to do so before the home visit.

(2) At the home visit, the home visitor should retrieve the completed questionnaires. If they are not completed, the visitor should ask the mother to complete them in the next few days and return them via mail in the lab-addressed stamped envelop provided. The home visitor should offer the mother another lab-addressed, stamped set of materials, in case the mother has misplaced them.

(3) If the mother is a nonreading mother, and for some reason the questionnaires were not administered in the lab, then the home visitor should prepare to administer these items in the home after the observation. Mothers should be told on the confirmation call that we will need to schedule approximately 3 hours for the home visit. If this cannot be done, then the lab team needs to be informed that they need to call the mothers to schedule a time to administer the questionnaires over the phone or at the mother's home.

(4) After the home visit, the home visitor should convey the questionnaire packet to the lab team or inform the lab team of their status.

(5) It is the lab team's responsibility to contact the mother for the questionnaires. They should call about at least twice, between 2 and 5 days after the home visit is completed.

3. When the home visit precedes the lab visit, but the mother does not bring the completed questionnaires with her to the lab: Instruction for the lab team.

a. If the mother has completed the questionnaires, but has simply forgotten to bring them, the interviewer should ask the mother to please return them via mail. The envelop she has may not have postage, so the interviewers should give the mother a stamped lab-addressed envelop with which to return the materials. However, the interviewers may also explain that, just in case she has any trouble locating the completed questionnaires, the interviewers has paced a new set of materials in the envelop. The mothers should remove these and put in her completed questionnaires and drop the packet in the mail.

(1) By enclosing an additional set of materials, we can speed their receipt, in case the mother has misplaced her original set.

(2) The lab team should call the mothers at least twice over the next 2 to 5 days to encourage the mothers to put the materials in the mail.

b. If the mother has not completed the questionnaires, the interviewer should give the mother a new set with a stamped lab-addressed envelop with which to return the materials. Follow the same guidelines as above.

4. When there is a home visit, but no lab visit: Instruction for the lab team

It is the lab team's responsibility to retrieve the MacArthur interview and questionnaire packet. In calling to contact the mother to schedule or reschedule the lab visit, the team member should encourage the mother to return the questionnaire packet within the next week, even if she cannot make the lab visit. This information is very important to us, and we value her input. Sites can offer to send the mother a $15 check on receipt of the completed materials.

5. When there is a lab visit, but no home visit: Instruction for the lab team

It is the lab team's responsibility to retrieve the MacArthur interview and questionnaire packet. The team member should call the mother and encourage her to return the questionnaires packet with in the next week, even if she cannot make the home visit. The packet we gave her is already stamped and self addressed, and all the mother needs do is fill out the questionnaires and drop it in the mail. This information is very important to us, and we value her input. Sites can offer to send the mother a $15 check on receipt of the completed materials.

6. When all else fails, lab team members can feel free to complete the questionnaires over the phone with the mother, if this is acceptable to the mother, of course. Sites can pay the mother for her time on the telephone, just as if we were getting this information in the mail from her. When questionnaires are completed over the telephone, this needs to be indicated on the questionnaire log.

Appendix E: Additional Monitoring Instructions

General Considerations:

The purpose of the Interviewer Monitoring Form is to document the reliability of the interviewers conducting the Standardized Interview and Questionnaires as part of the 24 Month Lab Visit. At 24 months, these forms will be sent to the Data Coordinating Center after they are completed by a certified monitor at each site. They will be stored at the DCC as a permanent record of interviewer reliability.

Each form that is required to document the reliability of the interviewer must be sent to the DCC. This includes forms on the first two pilot subject interviews used to certify the interviewer, the first two "real" subjects, and the first interview of each month after the initial certification. In addition, if an interviewer does not pass reliability at any point, forms on the first two "non-real subjects" used to recertify the interviewer and the first two "real" subjects must also be sent to the DCC. A copy of all of these forms must also be kept at the sites.

The monitoring form itself is not devised to provide extensive feedback to the interviewers. For example, only violations of reliability should actually be recorded on these forms. Interviewers need to know both what they do incorrectly and those things that they do well. Therefore, while monitoring provides an excellent occasion to give feedback to the interviewers, we suggest that the monitor also make more extensive notes than those recorded on the actual monitoring forms to share with the interviewers. Also, while monitoring is required on a monthly basis, interviewers may desire feedback at shorter intervals. (Some sites tape all of their interviews so that each one can be gone over if the interviewer has particular questions about certain interviews.) In addition, it is strongly recommended that each interviewer be made as knowledgeable as possible about the actual monitoring procedures, even if they are not certifying to become a monitor of other interviewers. The more explicit and clear these monitoring criteria are to the interviewers, the more they will understand what it is we expect from them.

Some changes have been made to the monitoring and interviewing procedures at 24 months. These changes are the product of feedback received from interviewers as well as from inter-site communication regarding these procedures. These changes are, in part, an effort to foster greater consistency across sites in the implementation of these monitoring procedures. Some of these changes seem minor but there are some important differences between the 15 and 24 month monitoring procedures. Thus, monitors that were certified at 15 months must learn these changes and must re-certify as monitors at 24 months.

To facilitate the process of becoming certified monitors, we have developed detailed instructions regarding the use of the monitoring form. These instructions, however, are not meant to replace careful study of this entire chapter. Intimate knowledge of both the interviewing and monitoring procedures is necessary to becoming a certified monitor.

If you have any questions regarding the general monitoring procedures or questions about how to use the monitoring form, please feel free to contact Wendy Robeson or Lyz Jaeger.

APPENDIX F: Instructions on the Use of and Scoring of the Interview Monitoring Form

Lyz Jaeger and Wendy Wagner Robeson

Each category will be discussed as it appears on the monitoring form.

1. READS

This category has lead to the greatest between-site differences in the use of the monitoring form. The following things should be noted in this category:

a. The interviewer reads every question as it is worded, every time she asks the question (unless the interviewer is "confirming" -- see below). On re-reads, interviewers often don't repeat the whole question and they should be deducted points for this each time it happens.

b. The interviewer should read all response choices every time she has to read the options to the mother. Interviewers frequently make the mistake of only re-reading the options which seem closest to what the mother is saying. (This particular type of mistake also borders on becoming a directive probe, but will only be counted under "READS.") Points should be deducted every time that this occurs.

c. Also included under this category is how the interviewer states the information in parentheses. There are several different types of information in parentheses:

1. If CHILD/HUSBAND etc. is in parentheses, the interviewer should read the proper name of that person. Points are not deducted for saying 'your child' instead of the name but if the interviewer fails to say the name consistently, it should be noted to the interviewer.

2. If the information in the parentheses is a definition of the intent of the question, then it should be read to every respondent and should be read exactly as it is written when the question is first asked. For example, see Section I, Q# 23. Points will be deducted for not reading this information exactly as it is written.

3. In several cases, information that may or may not be relevant to a particular family is printed in parentheses. This information must be read if it is applicable to a particular family or else points will be deducted. For an example of this type of case, see Section I, Q# 26. (See also Section I, Q#27 -- The parentheses should not be read if the mother reports that her child did fully wake up.)

4. In many questions, the parentheses call for the Month of the last visit or call. A change that will be made in the manual will instruct interviewers to say, "...when we last visited/spoke with you" or "Since I last came to see

you in _____" EVERY time the question states "Since MONTH". So the correct way of asking a question that begins with this phrase is: "Since May, when we last spoke with you,..." or "Since I last spoke to you in May". The interviewer must add this phrase each time the question specifies "Since MONTH".

Points will be deducted if the interviewer inserts the actual date of the previous visit or call in the context of an interview question. Interviewers are instructed to give the actual date of the last call or visit at the very beginning of the standardized interview and questionnaires. They may repeat this date during the transitions to a particular set of questions. In addition, if the mother asks when the last contact was made the interviewers can include the exact date when she re-reads the question.

The only time interviewers should not be adding the phrase, "Since we last visited/spoke with you...", is when there is missing data from the previous contact (call or visit). In this case, the interviewer should just be inserting the month of the child's 15 month or 21 month birthday. For further information regarding how to administer the interview when there is missing data from a previous contact, please see directions under "Interview Section 1" in this chapter.

d. Adding words to the question, especially in the middle of the question or at its end, counts as a violation of "READS" and points should be deducted for it even if it seems trivial. Sometimes, however, some questions can be prefaced in a way which does not count as a violation of "READS". For example, adding the word "And" to the beginning of the question or making a transition statement to a group of questions which has a clear ending before the question is asked (e.g. "This next set of questions also deal with your employment situation". "How many of your...") (Interviewers are expected to make their own transitions between sections of the interview.) However, if the statement prefacing the question could conceivably alter the meaning of the following question, then it should be counted against reliability.

e. Omitting words should be counted as a violation of "READS" even if it seems very minor. For example, interviewers frequently left the word "up" off of Section I: Q:26. While this word does not change the meaning of the question, it does change the way it sounds and may affect how the mother hears the question.

f. The way the interviewer introduces each of the Child Behavior Questionnaires (CBCL, ASBI) will also be monitored under "READS". While the interviewers do not have to read the introductory scripts to these questionnaires exactly as they are worded in the manual, they must convey the same information every time they introduce the questionnaires. The following information must be given each time the questionnaire is introduced:

1. CBCL: The interviewer must minimally tell the mother three things: 1) That the questionnaire concerns how her child behaves now or in the last two months, 2) to read the instructions at the top of the form before beginning the questionnaire, and 3) to feel free to ask the interviewer if she has any questions.

2. ASBI: The interviewer must minimally tell the mother that 1) the questionnaire concerns her child's behavior, 2) to read the instructions at the top of the form before beginning the questionnaire, and 3) to feel free to ask the interviewer is she has any questions.

These things must be said before each questionnaire or points will be deducted.

g. Interviewers frequently fail to read the Work Update prompts exactly as they are written. Points should be deducted if they fail to do so.

h. The transition sentences in the interview do not have to read exactly as written. However, some sentences that used to be part of the transition scripts are now part of the question. See, for example, Section I: Q31 and Q35. These statements should now be read exactly as worded because they are now part of the question and if they are not read as worded, points should be deducted for reliability.

i. While it is useful to note every instance in which the interviewer has not read every question exactly as is written (except where they otherwise confirmed the information), the following do NOT count as errors under READS:

1. If an interviewer reads two words as a contraction rather than as two separate words, no points will be deducted. Be especially careful, however, that the interviewer does not inadvertently change the tense of the sentence. If this happens, points should be deducted for reliability.

2. If an interviewer prefaces questions with a word like "And" OR "Next". If the interviewer does this frequently, it is worth noting to the interviewer but will not count against reliability. Be careful, however, that the interviewer is not inserting words before the question that may alter its meaning. For example, adding "On Average" before a question changes the meaning of that question EVEN IF that is what is the implied intention of the question. If the respondent needs help remembering that something is "on average", the interviewer should read the question as is, and then "step outside of the interview" to clarify that the question is about "on average".

3. Changing prepositions such as "spoke to you" versus "spoke with you" does not count against reliability.

4. Changing articles such as "this" to "that" will not count against reliability.

5. Inserting the word "that" after the words "Would you say" will not count against reliability. See, for example, Section I: questions #31 and #35.

6. In the Work Update prompts, the TAXES prompt may be read "Is this before taxes?" and no points will be deducted for reliability. This change was made because the question printed on the grid is not consistent with the question on the prompt sheet.

7. In Section II: Questions 23-28, points will not be deducted if interviewers do not read the phrase "Please choose one of ..." exactly as it is written.

8. And as already mentioned above, points will not be deducted if the interviewer says "your child" in the place of the child's name when the question states "CHILD".

Please NOTE: There are two questions printed on the interview form which are NOT to be read exactly as they are worded. Points should be deducted if the interviewer does not make the applicable modification.

1. Section I, Question #3: This question should be modified to read, "Do any children live in your home part of the time?". Interviewers must use this exact phrasing when asking the question.

2. Section I, Question #23: This question needs to be modified if the mother reported any special needs at the 15 month Interview. If the mother reported any special needs at 15 months, the question should be asked as follows:

"I see that at our previous interview you indicated that you had been told that CHILD had a (INSERT SPECIAL NEED). Is there any new information about CHILD'S condition?". If the mother did not report any special needs at 15 months, the question should be read exactly as it is written.

There has been considerable controversy regarding how much and when interviewers should adhere to the "READS exactly" rule. Remember, interviewers can choose to CONFIRM (see below), "step outside the interview", TRAIN the respondent, and PROBE. All of these make the interview more "friendly" and accurate. If you have interviewers who are making consistent READS errors which you think are trivial, please discuss them with Wendy Robeson.

It is rare for interviewers to have flagrant violations of this rule. Usually the mistakes are small, such as omitting or adding one word to the sentence. Even though these mistakes can look small, they often have subtle, yet quite conceivable, implications for the meaning of the question. While this rule may seem strict, it is important to note that many interviewers easily get to the point where they do not commit these errors and even if the commit four of these types of errors, they still pass reliability!

2. CONFIRMS

The only errors that are to be recorded here are those made when a question is confirmed rather than read exactly as it is written. Some people have put failure to confirm errors under this category but that is not the intention here. What we are really concerned with under "Confirms" is WHEN the interviewer does use confirmatory statement, do they use the meaning containing words in the original question.

A frequent error made by interviewers is that they attempt to confirm a mother's answer before they have enough information. Any case where an interviewer does not have full, clear information from the mother prior to asking the question, they should NOT confirm. If they do, this becomes a directive probe error and should be recorded as such.

A common mistake noted so far on the 15 month Interview is that interviewers are frequently confirming whether or not the mother moved since the 6 month visit. They are assuming that if the mother is at the same address, that she has not moved. This is incorrect. She easily could have moved and moved back in again since that time. This error would be scored as a PROBE error since it is a directive probe.

If an interviewer is confirming a question because of information heard prior to the Standardized Interview portion of the visit, they should repeat this information before they confirm the question so that the monitor will know that the interviewer actually had this information. For example, if the interviewer finds out earlier in the visit that the husband is no longer employed, the interviewer could say something like, "When we were talking earlier in the visit, you mentioned that your husband is not now working for pay."

3. DEFINES

This category refers to definitions that the interviewer gives the mother during both the interview and the questionnaires. Errors to be included in this category include offering definitions of subjective phrases to the mother, giving incorrect definitions of words for which the interviewer is allowed to give a definition, not giving the manual definition of a word if it is defined in the manual, and failing to note definitions given on either the Questionnaire Log or the 24 Month Laboratory Visit Monitoring Form.

4. RECORDS

There has been confusion over the use of this category and the "CODES" category. Errors noted under "RECORDS" generally refer to recording errors on questions where the interviewer must record exactly what the mother tells her in the form of pre-existing Scantron" bubble choices. The interviewer has to make no coding decision on these types of questions.

Common recording problems with the 15 month Interviews were that interviewers forgot to fill in the NA box for the secondary job in Section II: Question #2 and they also failed to fill in N's on Section I: Question #22, where applicable.

5. CODES

This category refers to questions where some coding decision is required by the interviewer. These questions are generally asked as open-ended questions and the interviewer determines which Scantron answer represents what the mother has said. The relevant items on the 24 Month Interview are: Section I: question #22 - 4c, 4d; question #23; Section II: Occupation code on Work Update, question #13, question #22). (Also, if Section I: #22 is asked simply as an open-ended question and answers are not confirmed with the mother, then errors in coding would also be noted here.)

The interview also calls for the recording of information that is not in the form of a Scantron answer. There are many places in the interview, for example, that ask the interviewer to "Specify". Although these answers may not seem as important as the Scantron answers, the answers to these questions should be recorded clearly and in a form that would be interpretable by someone other than the interviewer. If the interviewer consistently fails to record such information clearly over the course of the interview, count this as one instance of a disagree.

6. FAILS TO PROBE

A difficulty in noting these types of errors on the monitoring form is that they are likely to be confounded with recording or coding errors. Interviewers make coding and recording errors often because they do not have enough information, i.e. they failed to probe where it was appropriate. For purposes of the monitoring form, we will not double code interviewer errors. If a recording error is really the result of a failure to probe, record it only as a failure to probe. (If the recording error is the result of some other problem, record it under "RECORDS".)

Common probing errors include the following: 1) not getting sufficient information to record the mother's response exactly in the form that the Scantron options call for (for e.g. coding a Y or N response when the mother has not actually said either yes or no), 2) not probing "Anything else?" on all open-ended questions (such as with section I, questions 22, 33, 24, 36-40) -- failure to probe one question of this type will not result in deducted points but failing to do this twice or more will count as one failure to probe error and 3) not resolving factual contradictions during the course of the interview -- each error of this sort should be noted.

Also, please note the new probing instructions regarding Section I, Q #34 as explained in this manual. If the mother gives a response such as, "Yes, for a regular exam.", the interviewer is expected to do more probing. Failure to probe this type of answer should result in points deducted.

7. PROBES

Directive probes include any questions that may prejudice the mother's answer in any way. For specific examples, please consult section III.A.4. of this manual.

There are other types of inappropriate probes that are not necessarily directive. For example, if an interviewer asks a mother the same question twice and the mother has previously provided an answer that fits into one of the acceptable response options, re-asking the question is an inappropriate probe. However, if the interviewer has clear evidence (i.e., an answer to an earlier question, the mother's statement that she doesn't understand the question or is unsure of her answer), repeating the question of often the best approach. Put simply, if interviewers have "evidence" of inaccuracy or confusion, it is okay to repeat a question. If they don't have evidence, they shouldn't repeat "just on a hunch".

All instances of directive and inappropriate probes should be noted in this category.

8. SKIPS

Several different types of errors should be noted under "Skips". Failure to follow skip patterns, and failure to ask or confirm any single question that should have been asked are all included under "skips".

An interviewer should generally not be penalized for getting too much information. The only exception to this is when the interviewer asks questions about a husband/partner when the mother does not have a live-in husband or partner. Asking such questions is likely to compromise rapport.

A question which many interviewers have had is whether a skip problem that is soon corrected by calling the mother and getting the missing information should be counted against reliability. The answer is yes, these errors, even if soon corrected by the interviewer count as a "SKIP" error. The interview is meant to be given in person, not over the phone. Also, calling the mother back is another imposition on her time which we should seek to avoid. IF, however, the interviewer catches their skip error before leaving the home and records these questions being asked of the mother, it should NOT be counted as a "SKIP" error.

One common problem noted with the 24 month pilot interviews is that interviewers were failing to confirm the relationships of the household members to BOTH the mother and baby. If these are not confirmed, it should count as a skip error. Another common problem is that interviewers fail to confirm information especially when the mother answers the question in her answer to the previous question. Even if this happens, the interviewer is expected to confirm the information rather than to skip the question altogether. This is especially common with Section I: questions 20-22.

Another common skip error on the Standardized Interview is to fail to ask the mother to "specify" her answer (e.g. Section I, Q# 17) or for other additional information (e.g Section I, Q# 36-39 -- WHEN?). While this information is not recorded in a Scantron format, it is still important information and should be asked. (If these type of questions were asked, but no answer is written in on the interview forms, this will count as a RECORDING error.)

9. FEEDBACK

Interviewers must seek to avoid saying anything to the mother which may make her conscious about what the interviewer feels or thinks. Anything which conceivably could compromise the neutral context of the interview will count as a feedback error.

Several problems are common in this domain. First, interviewers still use words such as "O.K.", "Alright", etc. as filler between questions. While we are certain that many times mothers would not interpret this as an interviewer's evaluation of the mother's answer, we can never be sure that she won't interpret these words in that way. Thus, they are better avoided. (Also, when an interviewer uses these words repeatedly, she can sound as though she is cutting the mother off from offering additional information and trying to rush her through the interview). Each instance where this type of word is used counts as a feedback error.

A second problem that is common is that interviewers frequently want to say positive things to the mothers, particularly after they have expressed delight about something. For example, mothers are often happy to report that their babies had no health problems. Interviewers are likely to respond with statements such as "That's great". Unfortunately, what this seemingly nice comment may be doing is telling the mother that the interviewer would much rather hear about positive things rather than negative things such as health problems. Perhaps the best thing that an interviewer can do when a mother expresses delight or happiness is to "match" the mother's affect. For example, if the mother is smiling, the interviewer may smile too.

A third problem that interviewers have encountered is what to say if the mother expresses something that may seem very sad. In these circumstances, interviewers often want to offer words of sympathy. While this may seem like the polite and rapport-building thing to do, in some cases, the last thing the mother wants is for the interviewer to focus in on the issue by saying something about it. And, again, if the interviewer appears sad by what the mother has told her, the mother may censor other responses so as to not affect the interviewer's feelings. As with happy news, it is appropriate to match the mother's affect. If she appears sad, its okay to say "I'm sorry to hear that" and then continue the interview. It is important to emphasize that non-verbal behavior may be even more effective at expressing concern and respect for the mother's feelings than what the interviewer may actually say to the mother. Words are no substitute for sensitive, attentive listening particularly when the mother is discussing something distressing or of grave concern to her.

10. TRAINING

Training needs to occur both at the beginning and during the interview. One of the most common problems with training is that interviewers do not do enough of it, particularly with mothers who interrupt the interviewer. If a mother interrupts the interviewer two or more times while she is trying to read all of the response choices, the interviewer should train the mother by explaining the nature of the question. If the mother interrupts and the interviewer fails to train her more than once but less than four times, the monitor should deduct at least 10 points from the "Training" Score. If the mother interrupts four or more times and the interviewer fails to train her, the TRAINING score will be zero. In considering how to score this category, think of whether of the interviewer has made the mother's job as easy as possible.

11. PACE

This issue has not presented much of a problem for interviewers but a few things are worth keeping note of when scoring this category. First, make sure that interviewers are not speeding up as they read the response options. Second, make sure that even if the mother seems to be understanding everything, that the interviewer's pace is not too fast. Often, mothers want to rush through the interview because they have a time constraint and the interviewer speeds up to try to accommodate the mother. Instead of compromising the reliability and validity of the interview by reading the questions too quickly, the interviewer should tell mothers in this circumstance that they will try to complete as much of the interview as possible but that it might be necessary to either call her or visit her again.

24-MONTH LAB INTERVIEW ADDENDUM

During the lab visit when the interviewer refers to the home visit, she/he is really referring to when the interview was done last. Upon saying, "the last time we visited you," the mom may be thinking of her q-sort visit. (Since the lab is done after the home visit, the LAST visit was the q-sort visit, not the 15-month visit.)

To avoid this problem please alter the scripts as in the following examples:

> *"Now I'd like to ask you about* HUSBAND'S *health. How would you describe his health since ____ (we last visited you in March and did the interview) compared with other men his age?"*
>
> *or*
>
> *"Now I'd like to ask you about* HUSBAND'S *health. How would you describe his health since ____ (we last did the interview with you in your home in March) compared with other men his age?"*

CHAPTER 23

SECTION 7

OPERATIONS MANUAL: 24-MONTH GROWTH MEASURES

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CHAPTER 23

SECTION 7

OPERATIONS MANUAL: 24-MONTH GROWTH MEASURES

I. OVERVIEW

The manual includes information about the following:

- Rationale for measuring weight and height
- The procedure: timing, location, set-up and order
- Instructions to the mother
- Maintaining rapport with the child during the session
- Equipment and procedures for its calibration and repair
- Procedures for measuring weight
- Procedures for measuring height
- Form for equipment calibration
- Form for recording 24 month weight and height
- Training of visit coordinators

II. RATIONALE

Physical growth as measured by weight and height are essential indicators of health and nutritional status of young children. An appropriate rate of growth in both weight and height can serve as a rough indicator of physical well being and of adequate nutrition. An inappropriate rate of growth may suggest significant chronic disease. Consequently, growth measures are important dependent variables in this study of child development and are expected to be related to variations in the child rearing environments. More specifically, it is expected that in very poor quality rearing environments, children will be at risk for failure to thrive. Furthermore, differences among children in terms of growth parameters are expected to be related to the psychological outcomes of interest in the study. The patterns of interdependence between environment, growth, and psychological function will be investigated.

III. THE PROCEDURE: TIMING, LOCATION, SET-UP, AND ORDER

The procedure will take place at the very end of the laboratory visit, following the administration of the Standardized Interview and Questionnaires. The child and mother will be brought into a room with a scale and a yardstick for measuring height. The scale will be placed on either a table or on the floor. The yardstick will be taped to the wall, preferably next to a door jam. The mother will be told that if she chooses to stand next to her child, she is welcome to do so.

The order of measuring weight and height is not critical and visit coordinators will decide on the order that suits them.

IV. INSTRUCTIONS TO THE MOTHER

Following the administration of the Standardized Interview and Questionnaire, the child and the mother will be told that the very last procedure in this visit involves the measuring of the weight and height of the child, so we can tell how big he or she has become. The equipment will be shown and the procedures for weighing and measuring height will be explained to both mother and child. The mother will be told that at the end of the procedure she will receive a card showing how much her child weighs and how tall he or she is. The mother will be told that she can either sit and relax or that she can stand to the side of the visit coordinator. It should be made clear that both options are fine, as far as the visit coordinator is concerned. The mother should not be encouraged to choose one plan of action (or inaction) over the other.

V. MAINTAINING RAPPORT WITH THE CHILD DURING THE SESSION

One of the challenges to performing anthropometry on the 24-month old child will be to accomplish the task accurately without producing a physical struggle, a crying child, or an embarrassed parent. The visit coordinator's general approach to the child can help gain his/her confidence and dispel his/her fears.

Since it will be necessary to have the child undressed down to tee shirt and diaper (or underpants) to obtain the weight, this can be done by the mother or the child him/herself while the visit coordinator makes pleasant conversation with the mother. The visit coordinator will record whether the child was weighed in a diaper or underpants. If the mother objects to having her child weighed in a tee shirt (or an equivalently light top) and diaper or underpants, the visit coordinator will note this on the Weight and Length Measurement form.

Prior to performing any of the measurements, each step should be explained simply to the child, and should be demonstrated if possible with a doll. When offering explanations, it is suggested that the visit coordinator should be close to the child and at approximately the same head-level as the child. This position makes the visit coordinator less threatening and helps establish rapport. For some children, it is helpful to allow them to touch or handle the equipment in order to make them feel more comfortable with the measuring process.

During weighing, if the child has a tendency to reach out and touch the scale, he/she should be allowed to explore the scale for a little while. Then, the child may be asked to put his/her hands on or beside a body part, for example, on his/her hips or holding his/her own hands in front of his/her body. At the same time the mother may be asked to interest the child with conversation or with a toy that she will hold. Throughout the procedure, the child should receive praise and encouragement from the visit coordinator.

It is strongly advised that the visit coordinator avoid asking the child for his/her permission to do the maneuvers, since the visit coordinator is planning to do them in any case. Rather, the visit coordinator will proceed patiently, pleasantly, but firmly, attempting to convey to the child that there is nothing to fear and that the visit coordinator fully expects the child's cooperation.

VI. EQUIPMENT AND PROCEDURES FOR ITS CALIBRATION, REPAIR AND SANITATION

The equipment for measuring weight and height is the same at each of the ten research sites. The scale needs to be calibrated following the same procedures in each site.

Scales for measuring weight

The scale to be used in this study is the Health O Meter Pediatric Balance Beam Scale Model 1522KL. A drawing of the scale is shown in Figure 1 as well as in the Assembly and Operating Instructions that each site received with the scale. Each scale is an infant two beam scale with freely sliding non-removable weights (or poises). The scale has a screw type zeroing adjustment. The lower beam, or main beam, can be rotated to mark gradations in either kilograms or pounds. For this study we will record weight in pounds and height in inches. Therefore, rotate the beam to indicate pounds. The upper beam, or fractional beam, should be marked by ounces. The scale should be placed on a firm solid surface, preferably a table.

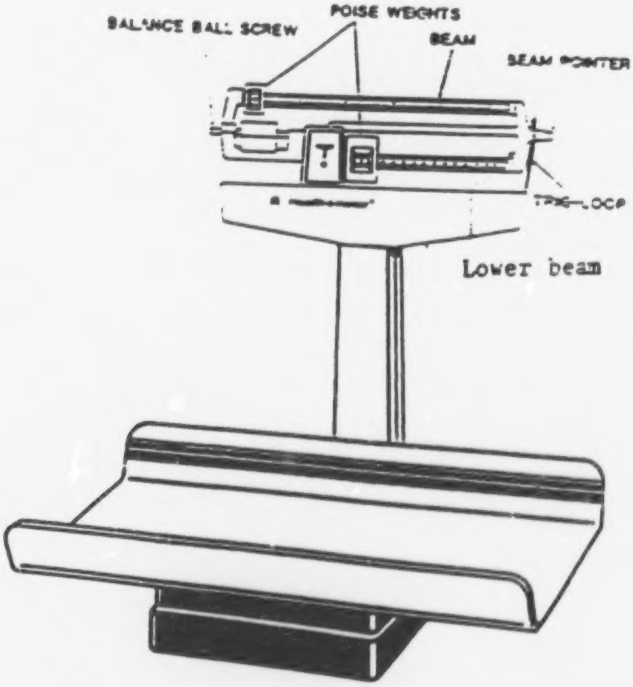
The calibration of the scale should be checked before beginning the 24 month assessments and every week thereafter to the end of the 24 months laboratory visits. Calibration will be done with a standard weight provided by NICHD. To calibrate,

Figure 1

Health o meter®

PEDIATRIC BALANCE BEAM SCALE

MODEL: 1522KL


BALANCE BALL SCREW
POISE WEIGHTS
BEAM
BEAM POINTER
TRIG-LOOP
Lower beam

zero balance the scale as described below. Place the standard weight on the scale platform. Move the weight on the main beam away from zero until the indicator points just above the center. Gently move the weight on the fractional beam away from zero until the indicator is centered. It may be necessary to move this weight back and forth several times to center the indicator. The weight should register the actual weight of the standard plus or minus 4 oz. on the scale. Weights provided to the sites as standards were not identical. Below is the weight of the standard provided to each of the sites:

Site	Weight of the Standard
0. Arkansas	23.58 lbs
1. California	24.47 lbs
2. Kansas	24.47 lbs
3. New Hampshire/Wellesley	24.03 lbs
4. Pittsburgh	24.25 lbs
5. Temple	24.03 lbs
6. Virginia	24.47 lbs
7. Washington	24.03 lbs
8. Western Carolina Center	24.47 lbs
9. Wisconsin	24.91 lbs

Scale calibration should be checked by a site specific designated individual with the standard weight every week during the 24 month assessments. If you find that your scale is not weighing the standard accurately (plus or minus 4 oz.), contact a local scale distributor to have the scale professionally calibrated. It is essential that scales at all sites are properly calibrated in order for the data obtained to be comparable. The Scale Calibration form (14H) will be used to record the weekly calibrations (see appendix). Form 14H is then sent to the DCC after 22 weeks of calibration.

The zero balance of the scale should be checked before the beginning of each laboratory visit by a designated individual. To check the balance, place the weights on each beam at the zero position. There should be nothing resting on the scale platform except when a cloth is used for the child's comfort. When the scale is in balance, the indicator at the right end of the beams will be pointing to the exact center of the space provided. If the scale is not in balance, adjust the balance ball screw. Generally, only a fine adjustment is necessary. The scale is balanced when the indicator points to the exact center of the space provided.

"Yardstick" and T-square for Measuring Height

Height at 24 and 36 months will be measured with a "yardstick" and a t-square. Each site is provided with a metal yardstick and a standard builder's t-square. Height was chosen as the measurement for the 24 month assessment because it is easier to perform, and more reliable and accurate for toddlers than recumbent length which was used at 15 months. Height is also the standard method of measurement for children this age.

The yardstick is to be taped to a wall, preferably next to a door jam. The bottom of the yardstick (starting with 0 inches) should be flat against the floor of the room and flush against the door jam, so that the yardstick and the floor are perpendicular to each other. The yardstick should be checked daily to ensure that it is securely attached to the wall and is positioned at a 90 degree angle to the floor. The t-square can be used to check that the yardstick is positioned vertically at a 90 degree angle to the floor. The t-square should be stored nearby so that it is accessible for the measurement procedure.

Sanitation

The scale should be covered with paper or wiped clean using soap and water after each child is measured.

Mobiles

Having a mobile above the child's head when the child is weighed and measured will distract the child's attention and may facilitate the ease with which the procedure is carried out.

Doll

A doll will be used to show the child how he/she will be weighed and measured.

VII. PROCEDURES FOR MEASURING WEIGHT

To measure weight, follow these steps:

1) The child's mother should be asked to undress the child down to tee shirt and diapers or underpants. The visit coordinator should record whether the child was in a diaper or underpants. If the child wishes to try and undress with no help

or with some help, this should be encouraged. If mother objects to having the child undressed, weigh the child in the minimal clothing approved by the mother and record what clothing the child has on at the time of weighing.

2) The mother or the visit coordinator should explain to the child that we want to find out how big he/she is.

3) Set the weights on both beams to zero.

4) Place the child sitting on the center of the platform seat of the scale. An interesting mobile placed above the scale may help focus attention of the child long enough to obtain the weight.

5) Move the weight on the main beam away from zero until the indicator points just above the center. Gently move the weight on the fractional beam away from zero until the indicator is centered. It may be necessary to move this weight back and forth several times to center the indicator. Read weight to the last completed unit.

6) Repeat the weight, taking the child off the scale, re-checking the zero balance and placing back on each time.

7) If the second measurement differs from the first by more than 4 ounces, record these weights and obtain two more weights according to the above procedure.

8) Remove the paper from the scale or clean the scale after use.

VIII. PROCEDURES FOR MEASURING HEIGHT

To measure the child's height, follow these steps:

1) Tell the child that you are going to see how tall he/she is.

2) Ask the child to walk over to the yardstick. Tell him/her that you want him/her to turn around and back up to the wall so that his/her back is against the yardstick. Make sure that his/her heels are both touching the yardstick/wall and that the child's head is against the yardstick. Ask the child to stand straight and tall.

3) When the child is in the correct position, place the t-square so that one arm is flat against the yardstick and the other arm is perpendicular to the yardstick and positioned several inches above the child's head. Slide the t-square down the yardstick so that the bottom side of it touches the top of the child's head. Be sure that the t-square is flat against the yardstick and resting lightly on the top of the child's head. Then ask the child to step away from the wall. As the child steps away from the wall hold the t-square securely against the yardstick.

If the child has a hair style which will add to the height, such as a ponytail, the mother should be asked to undo the hair in order to get an accurate measurement.

4) To read the height, look at the position where the bottom of the t-square meets the yardstick. Record the height to the last complete 1/8".

5) Obtain a second measure, verifying the proper position of the child as described above prior to each measurement.

6) If the second measurement differs from the first by more than 0.25 of an inch, record these heights and obtain two more height measurements according to the above procedure.

7) Wipe off the yardstick and the t-square with soap and water after measurement is completed.

IX. GOOD TECHNIQUES TO GAIN THE CHILD'S COOPERATION

A. General

Several of the mothers convinced their children to cooperate by promising them something. This worked very well. The vc might want to promise the child that he/she can play with a special toy after they are finished. Be sure to have an attractive toy handy if you use this strategy.

One site demonstrated the height and weight procedure with the reluctant child's older sister. This worked very well as the child cooperated with the vc after seeing his sister being weighed and measured. The height procedure can be demonstrated with the mother (or even another person at the lab) if there are no siblings present and if she agrees.

B. Weight

One site allowed the child to hold a Nerf ball while he was being weighed. The child enjoyed the ball, and it did not weigh anything. Good idea.

One site had the mother blow bubbles while the child was weighed. This worked really well, as the child was mesmerized by the bubbles and sat very still while the visit coordinator weighed her.

C. Height

Another site allowed the child to have her height measured first while sitting down. After the child realized that the procedure did not hurt, she cooperated by standing up.

One site put footprints on the floor where the children stand while the height assessment is made. This worked wonderfully to get the children in the correct position, as the children were able to put their feet on the footprints.

HEIGHT MEASUREMENT

MARK CODING PERIOD 24 36

CHILD ID NUMBER

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

DATE

Month		Day		Year 199_
0	0	0	0	0
1	1	1	1	1
	2	2	2	2
	3	3	3	3
	4		4	4
	5		5	5
	6		6	6
	7		7	7
	8		8	8
	9		9	9

INTERVIEWER ID

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

Child weighed in		
	Diaper	Yes No
	Underpants	Yes No
	Tee shirt	Yes No
	Socks	Yes No
	Other	Yes No

WEIGHT #1 lbs.		oz.		WEIGHT #2 lbs.		oz.		WEIGHT #3 lbs.		oz.		WEIGHT #4 lbs.		oz.	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2	2		2	2	2		2	2	2		2	2	2		2
3	3		3	3	3		3	3	3		3	3	3		3
4	4		4	4	4		4	4	4		4	4	4		4
5	5		5	5	5		5	5	5		5	5	5		5
6	6		6	6	6		6	6	6		6	6	6		6
	7		7		7		7		7		7		7		7
	8		8		8		8		8		8		8		8
	9		9		9		9		9		9		9		9

HEIGHT #1 inches (to 1/8")		/8	HEIGHT #2 inches (to 1/8")		/8	HEIGHT #3 inches (to 1/8")		/8	HEIGHT #4 inches (to 1/8")		/8
0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5
	6	6		6	6		6	6		6	6
	7	7		7	7		7	7		7	7
	8			8			8			8	
	9			9			9			9	

The NICHD Study of Early Child Care
Form 24G Revision 10/20/92

SCALE CALIBRATION

The Health O Meter Pediatric Balance Beam Scale is to be calibrated every week using the 25 lb standard weight provided by NICHD. To calibrate, zero balance the scale, place the 25 lb weight on the scale platform, and weigh the standard weight. If the weight is within ± 4 oz. of 25 lbs, the scale is accurate. If not, professional calibration is required.

Date of Calibration	Calibrator ID	Weight of standard in pounds & ounces	Professional calibration needed	Date scale professionally calibrated	Professional calibrator
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		

CHAPTER 24

ADMINISTRATION MANUAL FOR THE POST 24-MONTH FOLLOW-UP PHONE CONTACTS (27, 30 & 33-MONTHS)

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CHAPTER 24

ADMINISTRATION MANUAL FOR THE POST 24-MONTH FOLLOW-UP PHONE CONTACTS (27, 30 & 33-MONTHS)

I. INTRODUCTION

This chapter provides specific information about the questions included in the phone updates to be done at 18 and 21-months. In addition, it will serve as the archival description of the way in which phone-interview data were collected.

Any questions concerning these procedures should be addressed to Marion O'Brien or Aletha Huston at the Kansas site and Bonnie Knoke at the Data Coordinating Center.

II. INSTRUCTIONS FOR CALLING

It is crucial for sites to maintain regular contact with all families participating in the NICHD Study of Early Child Care. If a mother is not contacted at one of the phone update points, the chance of losing the family from the study increases. Therefore, it is important for sites to make as many attempts as necessary to reach the mother. If the family has a phone but the mother has not been contacted in the first three days of regular attempts, efforts should be increased to include evening and weekend calls. If the mother is not contacted by the end of the first week of attempts, begin to use the procedures outlined in

Section II.E, What To Do if You Cannot Reach the Family by Phone (page 5).

The child's mother must be contacted and interviewed in all cases. The only exceptions to this rule are situations where the mother is out of phone range for some unusual reason (serving in the military, for example) and will not return until after the data-collection window is closed. In this case, conduct the interview with the child's father if possible, or, if there is no father involved, with the child's primary caregiver. Indicate on the interview face sheet the relationship of the person who has been interviewed (0 = Mother, 1 = Father, 2 = Grandparent, 3 = Other Relative (includes sibling), 4 = Primary Caregiver, 5 = Support Child-care Provider, 6 = Child-care Provider (no hierarchial designation; use in instances where all classroom teachers are of equal status), 7 = Director (only in centers). If the mother is out of town but reachable by phone, she should be contacted wherever she is. If the mother is unreachable for a short period of time (e.g., in the hospital), arrange to call her back when she has returned home if this will be within the window for data collection.

If the mother is no longer living in the same household with the child, determine who has primary custody of the child and who the child's primary caregiver is. The legal guardian of the child should then be contacted and informed about the study. If he or she is interested in continuing to participate, a home visit should be made to obtain informed consent. At this time, if consent is given, the information on the update can be obtained using the appropriate Alternate Caregiver forms. Code relationship as above.

A. When to Make the Calls

Families should be contacted within a 3-week window, from 1 week before the child's 27-, 30- and 33-month birthday to 2 weeks after that birthday. Begin making calls at the beginning of the data-collection window (i.e., one week before the child's birthday) in order to complete as many contacts as possible within one week (plus or minus) of the child's birthday. The extra week is allotted for unusual situations where mothers are especially difficult to contact.

B. What to Do if You Cannot Complete the Interview in a Single Call

Families with young children have to cope with a lot of interruptions. If the interview cannot be completed at one time, arrange a specific time to call back before the end of the following day. Thus, the second call should be within 36 hours of the first call. If this is possible, the second interview can proceed from the point where the first interview left off. If more than 36 hours elapse between calls, begin the interview again, from the beginning. Say something like, "*I'm going to begin at the beginning to be sure we haven't forgotten anything.*"

C. How to Leave a Message

If you reach the family's home but are unable to talk with the mother, leave a specific message, including a time when you will call back. A suggested message to leave with another person follows.

> *"This is YOUR NAME from the NICHD Study of Early Child Care at the University of _________. We visited with MOTHER'S NAME about ___ months ago, and I am calling to see how she and Child are doing. She can reach me at PHONE NUMBER and DAYS/TIMES. I know she's very busy so I'll try to reach her again. Do you know of a good time for me to call? (Record day and time.) Thank you."*

D. An Alternative Message for an Answering Machine

> *"This is YOUR NAME from the NICHD Study of Early Child Care at the University of ___________ calling for MOTHER'S NAME. We visited with you in MONTH, and I am calling to see how you and Child are doing. You can reach me at PHONE NUMBER and DAYS/TIMES, and I'll call back DAY/TIME. Thanks."*

E. What to Do if You Cannot Reach the Family by Phone

If you are unable to reach the family by telephone because they do not have a phone, their phone is disconnected, their number has been changed to an unlisted one, or after a week of trying at all times of day and evening you have not contacted the family, special efforts must be made to reach the mother. The following steps are recommended:

1. Call work numbers if available. Unless parents have explicitly asked you not to call them at work, call the work numbers for either or both parents to arrange a convenient time to conduct the interview.

2. Make a home visit. When possible, the most effective approach to contacting a hard-to-reach family is for a project staff member who is acquainted with the mother to stop by the family's home. Often, people will not have moved if their phones are disconnected or changed to an unlisted number. The home visit should always be carried out by someone who has met the family, preferably someone who has been to the home before (one of the home visitors, for example). If the family has no phone, the interview can be carried out in person, or an alternate arrangement can be made for the interviewer to collect the information from the mother.

   If no one is at home but it looks as though the mother still lives there, leave a letter or card asking her to contact the project office. Be sure to let her know she can call collect.

3. Call the family's alternate contacts. Alternative phone numbers, which are updated at each contact point, are useful primarily for obtaining new addresses and phone numbers for study families. Leaving messages at the homes of alternative contacts is generally

not productive, although it can be tried. Asking alternative contacts to go and get the mother while you wait on the telephone is an imposition, and is not recommended. If the alternative contact can provide a new phone number or address, follow up on that by calling or making a home visit.

4. Send a letter with the project phone number and a return postcard to the family's last-known address. (A sample letter is included in Appendix B.) This prompt is often enough to encourage mothers to call you, or to send you their new address or phone number. Then you can follow up with a phone call or home visit. Be sure to let the mother know she can call you collect. Mark the envelope Address Correction Requested in order to receive a new address.

5. Call Directory Information in surrounding areas. The family may have moved nearby and still have a published phone number.

6. Check with the post office. Provide the family's last known address to the post office and ask for the newest address for the family. The post office will charge $1.00 per name to give the most recent forwarding address.

7. Call the child-care provider who was interviewed at the last data collection point. If the child is still in that provider's care, ask if you can deliver a message to the family through the provider. If so, take or send a

letter with return postcard for the provider to give to the family.

F. What to Do if the Family Is Not Contacted Within the Three-Week Window

If the above efforts are not successful and the family has not been contacted before the 3 weeks are up, continue to follow whatever leads you have to contact the family. A second call to alternate contacts is acceptable, but there is nothing to be gained by pestering them. Our guarantees of confidentiality prohibit us from contacting neighbors or others whose names have not been provided to us by the family. It is more important to protect the confidentiality of our subjects than to find every family at every contact point.

When all leads are exhausted, give up the effort until the next point of contact. Do not drop the family from the study because of missed phone contacts.

G. What to Do if the Mother Says She No Longer Wishes to Participate in the Study

When a mother tells you she wishes to withdraw from participation, ask, "*If you don't mind, can you tell me why you don't want to continue?*" Very politely, and without being insistent or coercive, try to reassure the mother.

1. If she says she's too busy, having another child, going back to work, or just feeling overwhelmed, say

"Yes, you must be really busy. Especially with all these new demands on your time and energy. We do our best to make things as easy as possible for you. There are no more than two visits per year, and we like to schedule them at your convenience. We can work around the other demands on your time."

2. If she says her husband/partner doesn't want her to continue, say

"What does he seem to be concerned about?"

Then listen. Acknowledge the mother's concerns. When she is done and leaves time for you, provide supportive information, and ask

"Would you like me or SITE P.I. to call him and talk with him about our study? We would be more than happy to speak with him."

Arrange a time to call if this would be helpful.

3. If mother continues to say she wants to withdraw, say,

"I'm sorry you feel you cannot continue. We would very much like Child to have the opportunity to participate in what we think is a very important study. But I certainly

understand your feelings. If you change your mind, please call us. And feel free to call if there's any other way we can help you."

Fill out the form for recording dropouts and send it to the Data Center.

III. RECORDING CALLS

The form, Record of Calls, is for use at the sites to keep track of all attempts to reach a mother. Every time the caller attempts to contact the mother, the date and time should be recorded and the result coded according to the codes listed at the bottom of the sheet. The interviewer's code or initials should also be marked on this sheet so that if more than one caller is trying to reach the mother, each one will know who has already left messages with the family. Any special situations should also be recorded on the reverse of this form. The Record of Calls is retained at the site in the family's confidential folder.

IV. FORMAT OF THE PHONE UPDATE INTERVIEW

Every Interviewer should become thoroughly familiar with the format, layout, and questions of the interview. Because of the many different family situations we expect to encounter during this study, the questions have been written to try to cover a great variety of responses. It is not possible, however, for the questions to suit every situation perfectly. At times the Interviewer must adapt a question slightly so as not to appear insensitive to a mother.

Within each section of the interview, there are a number of choice points when the Interviewer must skip over particular questions or sets of questions because they are not relevant to a particular situation. It is important that each caller be completely at ease with these choice points so that the interview can proceed smoothly and the mother be unaware of the many coding decisions and question selection decisions the Interviewer is making.

The conventions followed in this interview protocol are:

1. The directions to the Interviewer that are not intended to be read to the mother are printed in ALL CAPITAL LETTERS. The questions and comments to be read to mothers are printed in upper- and lower-case type.
2. The Interviewer is expected to continue to the next question unless instructed otherwise by a GO TO or choice point instruction.
3. Questions that must fit more than one situation are worded so that the choices between two wordings are in parentheses. Example: Last time we talked you (were/were not) going to school. The Interviewer is expected to choose the correct wording for this particular situation, not read both options. This requires that the Interviewer have the questions clearly in mind, understand the different possible

situations to which they refer, and have information about the family available.

4. Questions in which a person's name (or other specific information) is to be used indicate the missing information in capital letters, as, for example: Has Child had any ear infections? The question should be read as, Has Joshua had any ear infections?

V. MARKING THE FORMS

The mark-sense forms used for the interview must be filled in carefully. Use a #2 pencil and be sure to blacken the entire space to indicate the mother's response. Whenever there are 2 columns of numbers, as for month and day, for example, mark both columns. If your response requires only one digit, mark 0 in the first column.

For example, to record a date of February, 1989:

MONTH		YEAR	
0	2	19 8	9
▬	0	0	0
1	1	1	1
2	▬	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	▬	8
9	9	9	▬

The blanks above the columns are for your convenience in recording mothers' responses. Often it will be quicker to simply write in the response and then darken the mark-sense spaces later. This is especially true for complex questions that have several sets of responses, such as the household composition information.

In response to some questions, a mother may give you additional information that is not coded but that you want to record in order to demonstrate that what she wants to tell you is important, and also to help build rapport with the mother. You can write such information on the forms as long as you do not write over the mark-sense spaces. Try to keep your notes to the left side of the page.

VI. INTERVIEW SCRIPT

The interview data forms contain all of the introductory information you need to explain to the mother what is going to happen next. They should be read the way they are written. At the beginning of the interview, you may also find it helpful to add some informal conversation with the mother to make her comfortable, but do not spend too much time chatting before getting down to work. The mother appreciates your friendliness but will also appreciate not being kept on the phone too long.

Once you begin the questions, they must be read exactly as they are written. The only exception to this rule is the occasional situation where the information requested is obvious or already known to the Interviewer. In these cases, the Interviewer may reword the question as a statement, confirming with the mother that the information obtained previously is accurate.

Mothers have different ways of responding to interview questions. Some are very precise and specific, but others tend to give vague responses or answer in general ways that are not codeable. You can encourage mothers to be more specific by enlisting them as partners in the process of data collection.

For example, if a mother responds to the question,

"How many hours a week do you work?"

by saying

"15 or 20 hours"

you can say,

"I need to record a specific number of hours. Please give me your best estimate of the number of hours you work in a typical week."

The next time the mother responds with a range of numbers instead of a single answer, follow the same procedure. Usually after two reminders, mothers will understand the requirements of the interview and begin to give you codeable responses without prompting.

VII. INTERVIEWING TECHNIQUES

Be sure to read all questions exactly as they are worded. If the wording seems awkward to you, practice saying the questions aloud until you feel comfortable with them.

On some occasions, mothers may volunteer information during one part of the interview that you will ask them later. Remember what they have said, but do not flip through the interview pages to record that information. Instead, when you come to the relevant section, confirm the information you have received and ask, "*Is there anything else?*" For example, if the mother tells you right away that she's starting back to work next week, when you come to Question 12, "*Are you working for pay now?*" You can say something like, "*You said you're starting work next week. Right now are you working for pay?*" Whenever you are confirming information with the mother, use the wording of the question as written to the greatest extent possible. It is essential that you cover the content of every question. Do not assume information without confirming it, even if it seems self-evident.

Because the interview cannot exactly fit every possible situation for all the mothers in the study, there will at times be questions that seem to you inappropriate. In these unusual cases, you can say something like, "*The next question asks...*" Done politely and without belittling the question, this approach lets the mother know you are attuned to her individual situation, but also that you have a job to do and you take it seriously.

Do not interpret or reword questions. If a mother asks for clarification of a question or word, try repeating the question, perhaps with a slight change in intonation. Sometimes mothers may ask the meaning of a question that has a set of multiple choice answers. In this case, you can read her the options so she can select one of the choices.

VIII. FACE SHEET

The face sheet for the telephone contact is for use by the project staff at each site to help keep track of the information needed in the interview. This sheet is not to be sent to the Data Center.

Before calling, fill in all the indicated information on the face sheet, which is Page 2 of the interview forms, and also fill in the household information on Pages 5 and 6. Use the information collected at the most recent contact to fill in these pages.

During the call, you will get information on changes in addresses, phone numbers, and contact persons. Write this new information on the face sheet. Changes in other information on Page 2 obtained during the interview will be recorded on the interview forms themselves.

A second face sheet in mark-sense format is attached to the interview form. At the completion of the interview, fill in this form completely, with date of interview, interviewer's ID number, subject's ID number and relationship code, and child's age in months.

Once the interview is completed, separate the site face sheet and the record of calls from the interview itself and file them in the family's confidential folder. Have the interview forms checked by the site coordinator or her designee before they are sent to the Data Coordinating Center.

IX. THE INTERVIEW FORMS

This section of the manual provides specific information about the questions included on the phone update interview. Callers should read it through each day before they begin making calls to be sure they are thoroughly familiar with all coding rules and with the format of all questions and answers.

A. Part 1: Household Data

Question 1

You will have listed all the household members reported at the last contact before calling. The purpose of this question is to track changes in the child's household composition. Read to the mother the first names of the people you have listed, and ask if there are any changes. For people still present, fill in a 1 in the Change Code column. For anyone who is no longer present, fill in a 2 in the Change Code column.

If the child's father or another member of the household is temporarily away from home (for example, in military service), he or she should still be coded as part of the household. If this applies to the child's father, conduct the remainder of the interview considering him to live in the household.

If new people are added to the household, record their first name, relationship to the child, and relationship to the mother as she describes them to you. Record their age and sex and a 3 in the Change Code column. Assign the relationship codes listed above the grid after the interview.

Try to remember who lives in the household as you continue through the interview, because it will help guide whether to ask certain questions and the interpretation of some of the responses you receive.

Questions 2 and 3

Ask these only if the child's father has left the household since the last contact (that is, he has a change code of 2 for Question 1). If he had already left by the last contact, this information was obtained at a prior interview.

Question 2 is intended to establish the mother's legal and emotional relationship to the child's father. Response 1: Separated means that the mother is now married to the child's father but they are not currently living together by choice. Use these follow-up questions if the mother's initial response is incomplete:

Are you now married to FATHER?
Were you ever married?
Would you say you still have a romantic relationship?

B. Part 2: Health of Child and Mother

The time period included for all these questions is the interval since the last contact (about 3 months).

Question 4

Read the four choices and record mother's response. Do not try to interpret her answer for her, even if you think two runny noses are not a good reason to rate the child's health as "fair." You can add your notes about the mother's response, but you must code the answer she gives you.

Question 6

Mother should have received a positive diagnosis of "ear infection" from a physician or health professional to code 6a as "yes." Describe the medicine in her words. If she does not know the technical term for it, record what she does know (e.g., "some kind of antibiotic," "pink liquid that Child took for 10 days").

Follow-up with 6b only if the child has had any ear infections. If the mother says she doesn't know or the doctor didn't check, or she hasn't been back to the doctor yet, **LEAVE 6b BLANK.**

Questions 9 and 10

When you ask the mother how many times the child has been to the doctor, she will often begin to tell you the reasons. You can move immediately to Question 10 and walk her through the responses. To slow her down, giving you time to record, you can simply repeat what she is saying and confirm it. Your conversation might sound like this:

I: *"How many times?"*

M: *"Well, we went in early March for shots and then he got a bad cough..."*

I: (Turn to Question 10.) *"So he had a routine check up and immunizations in March?"* (Mark Response 1.)

M: *"Yes, and then he got sick."*

I: *"Was this a follow-up of an earlier problem or chronic condition?"*

M: *"No, this was the first time he'd been sick."*

I: *"So you took him to the doctor for a cough. What did the doctor say was wrong?"* (Mark Response 3.)

M: *"He had bronchitis."*

I: *"Was Kevin hospitalized for that?"*

M: *"No, but he was sick for a week."*

I: *"Has Kevin been to the doctor for anything else?"*

M: *"No, those are the only two times."*

I: (Record "02" under Question 9.)

Repeating and confirming the information with the mother allows you to obtain accurate information in a conversational manner.

Item 4b lists the conditions which could result from an injury. Because this is a phone call and card 13 can not be handed to the mother, read the list of conditions to her if she responds "Yes" to injury in item 4.

Question 11

Read the four choices to the mother and get her description of her overall health. Do not try to interpret her answer, even if you think differently than she does.

If mother begins talking about her health problems, respond pleasantly and as quickly as you can without being rude. Do give the troubled mother a chance to complain or explain, but do not encourage long descriptions of health problems. Often, a sympathetic "*I'm sorry to hear that,*" followed immediately by the next question, will get the conversation back on track.

Do record health problems described by the mother as these may be important in her ability to (a) work and (b) provide care for her child. Also, it will help build rapport with the mother if you ask specific questions about her health the next time you call her.

C. Part 3: Mother's Employment and School

An open-ended question is asked at the beginning for your information only, not for coding of occupation. It allows you to find out the kind of work the mother perceives herself as doing, so that you can talk intelligently with her about it. This is an opportunity to find out if the mother considers herself a mother and homemaker, if she has more than one job, if she is self-employed, or if her view of her job status has recently changed. This information can guide you in how to ask questions and how to interpret the responses, as well as where you need to probe more fully to get a complete picture. You will get a more specific description of the mother's occupational classification beginning with Question 17.

Question 13

A mother is working for pay now if she is employed for pay, either in or out of the home. This does not include the mother who is on leave and therefore still employed but not currently actually working. If a professional woman is officially on leave, she is not counted as working now even though she may spend some of her time at home doing professional things. Because we are updating employment information every 3 months, we keep track of the mother's return to work and any changes in her job status as the study progresses.

Question 14

This is intended to get current work situation, as of the day you interview the mother. If you are talking to her on Friday and she is starting work Monday, she is not now working.

If the mother says she works "full-time", explain, "*I need to get a specific number of hours. Please give me your best estimate of how many hours a week you work.*" Give the mother an opportunity to tell you what her actual work hours are.

If she works a variable number of hours, record the average number of hours per week, according to the mother.

Question 15

Count only hours at home for which she is paid, and, if she is a salaried professional, hours that are directly related to her paid employment. If the number of hours varies, ask for the "most typical situation" in the mother's opinion.

Question 16

If mother's work falls within one of the time periods listed in Question 16, record that period even if she does not work the whole time. For example, if she works from 1 to 5 p.m., record (1) Daytime. If she regularly works hours that overlap the intervals listed, record both times. For example, if she works a 12-hour nursing shift from 11 a.m. to 11 p.m., record both (1) Daytime and (2) Evenings.

Similarly, if a mother works days and evenings on a regular basis because of having two jobs, record both. If a mother works days one week and evenings the next, record (4) Times vary.

Question 17

Information on the mother's previous job status will be recorded on the interview face sheet. The same job means just that -- the exact position held with the same employer. A different job title with the same employer (resulting from a promotion or other change in duties) is recorded as a change. If she has the same position title and the same employer but a shift in place of work (for example, a teacher who moves to a different school in the same system), this is not a change.

If mother currently has one job, record Y or N under Job 1. If she has one job now, but had two jobs before, record Y for the job she now has and had previously (Job 1 or 2) and N for the job she used to have but no longer has. If she did not have a second job before, leave Job 2 blank.

If mother has two jobs now and one of them is different from her earlier employment, record Y for the job that is the same and N for the one that is not.

Continue to record Job 1 and/or Job 2 information under those columns throughout this section.

Question 19

Ask this question only if the mother's job title (Question 18) is not clear to you. Thus, if the mother says she is an insurance underwriter, you do not have to ask Question 19.

Question 21

This question is asked only if the name of the employer (Question 20) is not self-explanatory. If the employer is well-known to you, do not ask Question 21.

Question 22

Use the occupation coding definitions (Appendix A) to choose a category. Verify your coding with mother only if you are not entirely clear on the nature of her occupation. In that case, find an entry on the occupation coding chart that you think fits her job, and ask the mother if she agrees with your judgment. Do not ask her the category. For example, if you have learned that the mother works as a nurse, you need to find out if she is an RN (coded under Professional) or an LPN (coded under Technicians).

Questions 23 and 24

These questions are intended to complete the mother's work history since the last contact. The mother may have continued one job, quit a second job, and started a new job. You found out in Questions 17 and 18 whether she was still in the same job(s). Now you want to find out when she started any job that is new since the last contact, and when she stopped working at any job that has ended since the last contact.

On Question 23, record the most recent date she began a new job. Note this applies only to jobs begun since the last contact or jobs that were not recorded in the last contact. Keep Job 1 and Job 2 consistent with the previous interview. For example, record the dates under the Job 1 column if the mother has stopped working at the job previously recorded as Job 1 and started a new job. Keep these labels consistent even if the job previously recorded as Job 2 is now her primary job.

On Question 24, record a termination date for any job at which the mother is not currently working or on leave, even if she expects to go back (e.g., has been temporarily laid off). Record the date under Job 1 if she is not presently working at any job, but said yes to Question 13 (i.e., that she had worked for pay since the last contact).

Question 25

If you already know the mother is pregnant or has had another child, confirm that this is why she stopped work.

Otherwise, read the first five responses to the mother. Record Other only if none of these four fits her situation.

Mother's health includes her mental health. For example, if mother says she experienced too much worry about the child, emotional tension, or exhaustion, code Mother's health.

Child's health includes behavioral reactions of the child in child care, such as the mother's belief that the child was upset, unhappy, showing signs of distress if these have been manifested in physical symptoms such as stomach distress, sleep problems, or eating problems.

Childcare problems are the "external" problems of finding appropriate and affordable child care. They may include lack of available care, care that is too expensive or inconvenient, care that is unreliable or of poor quality, distrust of sitters, and the like.

Employer reasons include any reasons involving employers' actions or attitudes. For example, a mother may be laid off or fired, or the employer may have been inflexible about her need to take time off for family or personal reasons.

If the mother says something like she just changed her mind, or she thought she would be able to handle working and caring for her child but found out she couldn't, ask her if any of the listed reasons fits her situation. If not, record her reason under Other.

Question 26

Information on whether the mother was previously attending school will be recorded on the interview face sheet.

"Going to school" is defined as enrolled in an educational program that normally leads to a degree, certificate, diploma, or the attainment of job-related skills. Taking an evening course just for the fun of it does not count as going to school, nor does taking a parenting class offered by the local hospital. On the other hand, if the mother is taking an evening course on computers because she is planning to start a word processing business at home, then it should be recorded. Similarly, if the mother is enrolled in something like 6 credit hours at the local community college, she should be counted as attending school even if she is not officially in a degree program.

Knowing what kind of school the mother is or was attending is important for later questions and also for building and maintaining rapport with the mother. Although this information will not be coded into the data base, it will be important for you to know in future conversations with the mother.

Question 28

The intent of this question is to find out how much time the mother was spending doing school work -- time in class plus time spent on school-related work. As a general rule, use the following coding rules for counting hours in school. For high school or vocational school where people enter a building and attend classes for a portion of each day, count the number of actual school hours (e.g., 8:30 to 3:30 for five days a week would count as 35 hours). For community college, college, or graduate school, count the number of credit hours in which people are enrolled, multiplied by 3, to get an index of involvement with school (e.g., a student enrolled in 12 hours -- which is considered a full-time load -- would be recorded as going to school for 36 hours; a student enrolled for one course of 3 hours credit would be recorded as going to school for 9 hours). Although different types of schools will vary somewhat in their time requirements, these calculations will provide a general index of time spent.

Question 29

If mother's school hours fall within one of the time periods listed in Question 29, record that period even if she does not go to school the whole time. For example, if she attends school from 1 to 5 p.m., record (1) Daytime. If she regularly attends school during hours that overlap the intervals listed, record both times. For example, if she is in school from noon to 7 p.m., record both (1) Daytime and (2) Evening.

Questions 30 and 31

These questions are intended to complete the mother's school history since the last contact. The mother may have started and stopped going to school during the past 3 months.

D. Part 4: Husband/Partner Employment and School

If a husband or partner lives with the mother, get this information about him. We will not inquire about nonresident fathers or partners on these updates, although we will do so during home visit interviews. If the husband/partner is temporarily away from the family (e.g., in the military), do ask these questions.

Information on the husband/partner's job situation will be recorded on the interview face sheet before the call is made. An open-ended question is asked at the beginning of this section for the Interviewer's information only. It allows you to probe for whether the husband/partner has more than one job, is away from home temporarily, or is self-employed. More specific information about the husband/partner's job classification is obtained beginning with Question 35.

Question 33

The response to Question 33 should include total hours working at all jobs. The following questions also concern all jobs. The issue we are interested in is how much time he is available to help with child care and other home responsibilities.

If the mother replies that he works "full-time", explain the kind of response needed. For example, say, "*I need to get a specific number of hours. Please give me your best estimate of how many hours a week he works.*" Give the mother an opportunity to tell you what his actual work hours are. If the mother gives you fractions of hours (as 37½ hours) round to the nearest whole number, counting 0.5 or more as the next higher number and anything less than 0.5 as the next lower number.

If the husband/partner works a variable number of hours, record the average number of hours per week he has worked for the past month. Work at home for which he is paid should be included. If he is a professional who regularly brings work home, the hours spent on work that is part of his paid employment should be counted.

If the mother reports that the husband/partner is away from home overnight on a regular basis, or that he often has job assignments that take him away from home for periods of several days or weeks at once, code Question 33 as 99.

Question 34

Even if the mother has told you his employment situation has not changed, confirm with her the husband/partner's job title. Prior partner employment information is obtained from the last 3-month phone call update.

Questions 35 and 36

If the husband/partner has a new job and you know that job title from the mother's response to the open-ended question about employment, confirm it here. "*And you told me HUSBAND/PARTNER was an English teacher.*" If the job title was not clear from the earlier conversation, ask, "*What is his position title?*"

In this section, we are collecting information about the husband's/partner's current job situation, as of the day of the interview. We will update this information every 3 months during the course of the study. If the mother reports that the husband's/partner's current situation is very unusual (for example, he is working as a melon weeder for the summer while looking for a job as a corporate lawyer), assure her that we will learn about the job changes periodically and record information about current employment. If, on the other hand, the father has a temporary summer job because he is a schoolteacher, record information about the teaching job, if the mother defines that as his primary job. Do not collect information on more than one job. Let the mother define which job is primary, and collect information only on that job.

Question 36 needs to be asked only if the position title (Question 35) is not self-explanatory. If the position title is Elementary School Teacher, for example, you can skip Question 36. But if the mother says her husband is a Retrofit Specialist, you should probe for a more understandable description of his job.

Questions 37 and 38

Question 38 should be asked only if the response to Question 37 is not self-explanatory. If the employer is well-known to you, do not ask Question 38.

Question 39

Use the occupation coding definitions provided (Appendix A) to code occupational category. Verify your coding with the mother only if you are unsure of the husband's/partner's occupation. In that case, find an entry on the occupation coding chart that you think fits his job, and ask the mother if she agrees with your judgment. Do not ask her the category. For example, if you have found that the father works in a lab for an environmental consulting firm but the mother is vague about his duties, you look on the occupation coding chart and find two possibilities. Ask "*Would you describe him as a biological or life scientist (Professional category) or a biological technician (Technician category)?*"

Question 40

"Going to School" is defined as enrolled in an educational program that normally leads to a degree, certificate, diploma, or the attainment of job-related skills. Taking an evening course in conversational Spanish just for the fun of it does not count as going to school, nor does a parenting class offered by the local hospital. On the other hand, if the child's father is required by his employer to take the Spanish class because he is going to attend a sales conference in Chile, then it should be recorded.

Question 41

The intent of this question is to find out how much time the mother's husband or partner spends doing school work -- time in class plus time spent on school-related work. As a general rule, use the following coding rules for counting hours in school. For high school or vocational school where people enter a building and attend classes for a portion of each day, count the number of actual school hours (e.g., 8:30 to 3:30 for five days a week would count as 35 hours). For community college, college, or graduate school, count the number of credit hours in which people are enrolled, multiplied by 3, to get an index of involvement with school (e.g., a student enrolled in 12 hours -- which is considered a full-time load -- would be recorded as going to school for 36 hours; a student enrolled for one course of 3 hours credit would be recorded as going to school for 9 hours). Although different types of schools will vary somewhat in their time requirements, these calculations will provide a general index of time spent.

E. Part 5: Child Care

Coding Child Care Arrangements

Mothers will answer the questions about child care arrangements with more conventional descriptions (childsitter, nanny, etc.). The responses on the interview form are not intended to be read to parents. Rather, they are for your use in coding the type of arrangement the parents have made for child care. Thus, if the mother says they have found a sitter, you will need to ask if the sitter is a relative and whether he or she comes into their home or they take the child to the sitter's home.

Be sure to code all arrangements, even if some of them are informal, such as the child's father staying home until 9:00 every morning. Although many mothers will not think of this as a child-care "arrangement", it is to us. Backup arrangements that are not regularly scheduled but available for emergencies are not recorded. Use Arr. 1 for the arrangement used for the most hours, Arr. 2 for the next, and Arr. 3 for the third. Do not code more than 3 arrangements.

Examples of probe questions to ask:

Mother's Response	Query
My neighbor is caring for Child.	1) Is your neighbor related to you? 2) IF NO, code (a) 6 3) IF YES, What relation? 4) Is Child cared for at your neighbor's house? 5) IF YES, code (b) 2 6) IF NO, Where is Child cared for? 7) Does your neighbor care for Child during all the hours you work? 8) IF NO, What other child care arrangement do you use?
My church has a nursery that I use.	1) Who cares for children in the nursery? 2) Is the nursery open during all the hours you work? 3) IF NO, What other child care arrangement do you use?

My husband is taking time off when I'm working.	1) Does he care for Child at home? 2) Is he able to care for Child during all the hours you work? 3) IF NO, What other child care arrangement do you use.
I've hired a nanny.	1) This is someone who comes to your home to care for Child? 2) IF NO, Where is Child cared for? 3) Is this person related to you? 4) IF YES, What relation?

Question 42

The purpose of this section is to get information about all the family's regular child-care arrangements. Regular means that the mother has some standing arrangement with another person to care for the child at a specified time. This may include short periods of childsitting. For example, if the mother has a regular evening or Saturday afternoon when her husband/partner is expected to be responsible for the child, this is a regular arrangement. Also, if the mother leaves the child with her mother every Thursday afternoon, or expects an older sibling to be responsible for the child from 4 to 5 every day, these count as regular arrangements. If she occasionally hires a sitter to go out in the evening, this is not a regular arrangement. Back-up arrangements, or those set up in case of illness, do not count as regular arrangements.

Questions 43

If mother has responded to Question 42 with NO but responds to Question 43 by telling you that the child's father is helping her with child care while she works, go back to Question 42 and score YES. You may then restate Question 44 as a statement: 44.(a) Child's father will care for Child. (b) *"Where will they be?"*

Question 44

Code all current arrangements the mother is using. If she begins to tell you about future plans, explain that we will be gathering information on changes in child-care at later interview points, but right now we want to know about her current child-care situation.

Questions 45 and 46

The purpose of these questions is to find out how many other children are usually present when the child is in the care setting, and how many regular caregivers the child has. In a day-care center record the number of children in the child's group or classroom, not the number in the whole center. In both centers and homes, the number may change during the day. Ask the mother for the typical number present during the majority of the time the child is in the setting. For example, if three kindergarten children are cared for by the child's caregiver from 4 p.m. on, but the target child is cared for from 8 to 5, do not count these children as part of the typical group. Base the typical group on the current situation; group sizes will also change seasonally.

In counting caregivers, ask the mother for the number of different people who supervise the children on a regular basis. For example, if the child's group has a head teacher who is present all day, two assistants in the morning and two different assistants in the afternoon, the number of people supervising the children is 5. If a home child-care provider has a teenager or another adult who regularly assists with the children, and the caregiver's husband is in charge every day after 4:30, the number of people supervising the children is 3.

Questions 47 and 48

These questions are intended to get at the pattern of child care as well as the total number of hours. Thirty hours divided over 3 days is a different experience for the child than 30 hours divided over 5 days. In cases where the child's schedule changes from week to week, ask mother for the "most typical" situation in her opinion. We will obtain more detailed information about schedules when we do child-care visits. If the word "arrangement" is awkward for the situation of the family you are interviewing, reword Question 69 to say, for example, *"How many hours a week is CHILD cared for by your mother?"*

Question 49

For responses in weeks or parts of months, round to the nearest month. If the mother says 26½ months, ask her if it was closer to the child's 26 month or 27 month birthday. You can also get the date of enrollment and calculate the child's age, confirming the age in months with the mother.

Question 50

If mother volunteers a codeable response immediately, record that. If not, say, "*Which of these reasons was the most important? I'll read you the list; there are 10 choices. Cost? Convenient hours? Convenient location? Quality of care provider? Quality of environment and equipment? Quality of program? Preference for relative to provide care? Preference for home environment? Preference for center environment? Availability?" Record only one response. If mother says several were important, say, "Which would you say was the most important reason?*" If you begin reading the list, try - politely - to get through the entire list, even after the mother picks one. Then confirm that her initial response was the most important reason.

Question 51 to 58

These questions are intended to get a complete history of child care used, even arrangements that were used only briefly. Ask Question 51 of all mothers, even those who are not now using child care and who were not using child care at the last contact. Follow the same coding rules for Questions 52 to 58 as described above for coding current arrangements.

Question 59

This is a question about child care, not about health. The intent is to find out if parents have had to modify their child-care arrangements because of illness, or have been concerned about the special needs of a sick child.

Question 60

When a child is sick, mothers often have to piece together a patchwork of care. Record one or two emergency arrangements the mother made.

Question 61

A "day" of work means a significant amount of work. Code Yes if one parent missed a half day or an important work obligation, such as an important meeting or appointment.

Question 62

Read the list of possible problems if the mother does not immediately volunteer a codeable response.

Question 63

The purpose of this question is to identify any important events impinging on the mother or the family and give the mother a chance to talk about anything that's important to her that has not been covered in the interview. Important events can be happy or sad. Record whatever the mother says is important to her.

X. DEBRIEFING

Follow the script as written, being sure to give the mother a chance to ask any questions she may have. It is a good idea to make a note of any questions and what your response is, and to check with your Site Coordinator and/or P.I. to be sure all staff members are following the same procedures. If you are at all unsure about the answer to a question, do not try to answer it. Instead, tell the mother you will find out and call her back. Talk to the Site Coordinator and/or P.I. and arrange for someone to call the mother back within that same day if possible.

Conclude the interview by telling the mother when she will be contacted next and what will happen at that contact.

XI. APPENDIX

A. Occupational Codes (same as laminated sheet at each site)

B. Sample Letter To Send To Mother When Unable To Contact By Phone

Sample Letter to Send to Mother When Unable to Contact by Phone

Mother's Name
Last Known Address

Dear _________:

Thank you for agreeing to participate in the NICHD Study of Early Child Care. We have enjoyed getting to know you and Child, and it's good to have you as part of the study.

We have been trying to contact you to find out how you and Child are getting along. Please fill out and return the enclosed card to us, or call our offices at AREA CODE/PHONE. Feel free to call us collect. Also, you can call at any time and leave a message on our answering machine. Please let us know the best way to contact you.

We hope things are going well for you and Child and we look forward to hearing from you soon.

Sincerely,

Project Staff Member

Enclosure: Return postcard